Family Experiences Concerning Adopting a Previously

Institutionalized Child from Russia or Romania

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FAMILY EXPERIENCES CONCERNING ADOPTING

A PREVIOUSLY INSTITUTIONALIZED CHILD FROM RUSSIA OR ROMANIA

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(ABSTRACT)

The number of families choosing to adopt a child internationally in the United States has increased exponentially on an annual basis (Johnson, 1997; Miller, 2000). The purpose of this study was to understand the adoption process experiences of families who have adopted a child between the ages of three and five years old from Russia or Romania after 1992. In this clinical sample, all participants' adopted children had been referred for and undergone neuropsychological, medical, speech, and/or language evaluation. Specifically, the research questions were designed to help therapists understand the role mental health care professionals, schools, family members, and friends played in the adoption process and how the participants' experiences compared with their preadoptive expectations. Twenty families were interviewed and several observations were conducted. Data analysis consisted of thematic analysis which elicited codes and themes across the interviews. This study's findings suggest that: 1) parents would have found more preparation before adoption helpful in the process; 2) health care professionals and schools need to be better educated about problems, concerns, and appropriate treatments specific to post-institutionalized children; 3) raising (a) special needs child (ren) puts significant strain on the caregiver(s) and their significant relationships; and 4) families with special needs children are extremely resilient. These findings are important for education and healthcare professionals, families who are planning to adopt internationally in the future and current adoptive families.

Dedicated to my Grandpa, Elbert Linville

ACKNOWLEDGEMENTS

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CHAPTER I: INTRODUCTION

Problem Statement

Every year, thousands of children from more than one hundred countries are adopted and join families in the United States (Johnson, 1997; Miller, 2000). In 1989, there were almost 8,000 international adoptions. While in 2002, adoptions increased to more than 20,000 children (Immigration and Naturalization Service and U.S. Department of State, 1989-2002). The majority of adopted children who joined families in the United States in 2002 were born in Russia, Romania, China, Guatemala, Ukraine, and Korea (Immigration and Naturalization Service and U.S. Department of State, 1989-2002).

International adoption has been occurring for many years in the United States and the continuing increase in children adopted from abroad is attributed to a number of factors including: 1) a large number of younger children (infants and toddlers) available for adoption abroad; 2) prospective parents' perceptions that the international adoption process is faster, more cost effective, and less likely to be encumbered by interactions with a child's birth family than the domestic adoption process; and 3) increased media coverage of institutionalized children who are deprived, abandoned, neglected, and in need of families (Federici, 1999; Goldberg & Marcovitch, 1997; Johnson & Dole, 1999).

Most children adopted by U.S. parents from other countries have lived in institutions for at least a portion of their lives prior to adoption (Johnson, 1997; Miller, 2000). The increase in international adoption suggests a need for more health professionals with knowledge of medical and mental health issues specific to internationally adopted children and their families, as well as additional services and various resources to support these families. A number of studies have concluded that developmental concerns, growth delays and many other medical problems are correlated with institutional living (Federici, 1999; Johnson, 2000; Miller, 2000). Due to these conditions, internationally adopted children are now accepted as an at-risk group that needs specialized medical and mental health attention (Miller, 1999).

The experience of adoption includes not only the actual legal event but also a lifelong process for the adopted child and their family from that point forward. Researchers suggest that adoptive families may have additional concerns not always present in birth families (Pavao, 1998). Because international adoptees' typically face greater medical and psychological

problems researchers, clinicians, and families are striving to achieve a greater understanding of, and provide resources for, internationally adopted children and their families. Developmental, emotional, educational, and behavioral concerns of international adoptees are not well reported in the literature, but dysfunctional behaviors are seen more frequently in adopted children of any national origin than in birth children (Rhodes, 1997). These dysfunctional behaviors may include: inability to give or receive affection; self-destructive behavior; cruelty to others; phoniness; problems with food; preoccupation with fire, blood or gore; superficial attraction to and friendliness with strangers; substance abuse; and promiscuous sexual activity. Adoptive families most often deal with a combination of these behavioral problems while simultaneously dealing with the child's medical problems and adjusting to their new role as parents.

Purpose of the Study

Several researchers have examined the medical aspects of diagnosis and treatment of international adoptees but have not examined the psychosocial needs or treatment in this population. Risk factors for internationally adopted children predictive of emotional, cognitive, and developmental concerns have been identified. However, few studies have either determined the impact of institutionalization on the children and their families or identified protective factors for families adopting Eastern European children of toddler age or older. Although many clinicians have suggested treatments and resources for these children and their families, little research has examined the perspective and experiences of adoptive families. Oliver (1998) concludes that research based on self report from families, adoptees, and clinicians who have tried to help this population of children is vital and especially useful to practice.

Therefore, I have aimed to understand the adoptive families' experiences and how they are similar or dissimilar to their expectations. In addition, I have gathered information on how health professionals and schools could work collaboratively to meet the medical and psychosocial needs of adoptees' and their families.' Most importantly, I have gained an understanding of the participants' experiences with their families, friends, and society at large. Thus, this study provided a first step toward understanding the adoption process experiences of families who have already sought healthcare consultation for an adopted Russian or Romanian child between the ages of 3 and 5 years old.

My primary goal was to understand the subjective reality of the adoptive parents and how they perceive their experiences with adopting a child from Russia or Romania. While attempting

this task, I also kept in mind the shifting aspect of their experiences as the participants evolved with respect to their thinking about themselves, their families, the adoption process, and their experiences. I also tried to understand how participants perceived the care they received from mental and medical health professionals and the ways they felt these professionals could be more helpful.

Self of the Researcher

From my diary in Romania, Summer 2001:

As I walked into the building for the first time, I was less overcome by the sights than the smells. The odor was so overwhelming I nearly gagged and my nose scrunched up only a few feet inside the front door. Of course I immediately felt guilty, because I knew that the children in the *Camin Spital* had to live with those smells every day, every hour, every minute. I also hoped no other team members had seen my reaction. This feeling of guilt was an emotion I grew very used to during the days that followed.

I spent the next 36 hours in a state of shock at the conditions of the institution and the physical and mental ailments of the children around us. Many would run up to us and throw their arms around us, uninhibited, craving any attention we could give. Of course these were the children who were mobile; many children were paralyzed. So many children we saw during our visits were paralyzed, drooling, autistic, starved for attention, starved for water, for food — the weakest of the weak in a country so poor that simple preservation came before anything else.

My interest in and involvement with examining the experiences of families who have adopted internationally has spanned several years while I simultaneously have reviewed the neuropsychological evaluations of children referred for comprehensive cognitive and emotional evaluation. This past summer, I traveled to Romania with a group of doctors and worked in several institutions/orphanages for children. The conditions I saw in the Romanian institutions were desolate and disheartening. After witnessing these children's emotional, physical, cognitive, and social deprivation, I was compelled to conduct research in this field to facilitate the understanding of professionals working with this population of adoptive parents and adopted children. Specifically, this endeavor furthered my interest in learning about how parents

experience the adoption process and how families' strengths and resources altered their perceptions, roles, and experiences.

Along with my heartfelt interest in understanding the experiences of parents who have adopted from Eastern Europe, I also have a passion for learning how to effectively collaborate with medical professionals. My interest increased when I traveled to Romania with a group of medical professionals and neuropsychologists. I started to learn the medical language and was constantly thinking about how my education and expertise could augment their existing knowledge base. I asked myself the question, "How can I be helpful as a marriage and family therapist?" I am still asking that question and I feel that this study is one way that I could help these children and their families after adoption as a member of the health care team. I firmly believe that if medical and mental health professionals collaborate to address the complex needs of these children and their families, the needs of these families will be better served.

Conceptual Framework

Sprenkle and Moon (1996) outline several primary assumptions of phenomenological research. First, knowledge is socially constructed and therefore inherently tentative and not whole. Second, researchers are not separate from the phenomena under study. Third, bias is inherent in all research regardless of the methods used. Fourth, common, everyday language about family worlds is epistemologically important. This proves significant in trying to decrease power in the researcher-participant relationship because no one is seen as the expert. Fifth, language and meaning in everyday life are significant. Finally, objects, events, or situations can mean a variety of things to a variety of observers – in this case, different family members.

I incorporated these assumptions in my work in the following ways: I did not try to separate myself from the research and referred back to my own journal entries, field notes, and observations throughout the process; I allowed participants to create their own meaning regarding their experiences and checked back with them to ensure that I understood their meaning; I transcribed the interviews verbatim and included direct quotes from the interviews in my findings so that I was sure to include their language; and when presenting my findings I tried to display the range of responses I received from participants.

Marshall and Rossman (1995) discuss phenomenology as having two implications including the subject matter under inquiry and the methodology. A phenomenologist is described by Bogdan and Taylor (1975) as someone who "is concerned with understanding human

behaviors from the actor's own frame of reference…he or she examines how the world is experienced. For him or her, the important reality is what people imagine it to be" (p. 2). The purpose of my study lent itself to the phenomenological research methodology and to phenomenology as a theoretical framework as I aimed to understand the experiences described by the participants.

The phenomenological discipline is devoted to "entering into the field of perception of participants and seeing how they live and approach the phenomenon, and looking for meaning in their experiences" (Creswell, 1998, p. 31). True phenomenology attempts to use pure description to find the meaning and/or essence of an object or experience. This qualitative approach allows attention to be focused on the individual's perspective and understanding of the experience as it specifically relates to them. Stanage, as cited in Houle (1992), describes phenomenology as "a philosophical movement whose primary objective is the direct investigation and description of phenomena, as consciously experienced, without theories about their causal explanation and as free as possible from unexamined preconceptions and presuppositions" (p. 68). According to Bogdan and Taylor (1975), the phenomenologist wishes to understand an experience from the participant's point of view. I achieved this goal of phenomenological research in the current study by allowing participants to come up with their own meanings and interpretations of their experiences, by reporting their words exactly as they said them, and by making interpretations of these findings only after I was clear on how they made sense of their experiences. After I made the interpretations, I checked back with participants to see if they agreed with my findings and interpretations.

R*esearch questions*

I constructed these research questions based on the pre-existing literature, my research interests, and responses I received to pilot questions. There is a paucity of information in the existing literature on international adoption especially regarding family experiences of the adoption process. Likewise, I have a special interest in learning from the parents who have been through the adoption experience, as I view them as the experts. My pilot study data further validated my existing research interests, as participants also felt that they had not had their experiences heard or validated. They also felt that they had lot of important information to share. My interest in this topic, my respect for parent perspectives and parent report all impacted the development of my research questions. These questions facilitated my understanding of: 1) the

adoptive parents/families' approach to adoption; 2) the role mental and medical professionals served in these families' adaptation and survival after adoption; 3) how the families' experiences were different or similar to their pre-adoption expectations. Obviously, there are many avenues I could take to understand the experiences of these families. I chose to focus on what I felt would give me the richest descriptive information: their personal stories.

The research questions guiding the inquiry process included the following:

- How do participants' best describe their family before, during, and after adoption in regard to their roles and rules?

- How do participants' experiences compare with their expectations when they initiated their adoption process?

- How do parents describe the role that mental health, educational, and medical professionals have played in the lives of families who have adopted a child from Russia and/or Romania? How could these professionals have better collaborated to meet their needs?

- What has been the social response throughout the adoption process?

- What are adoptive families' experiences with the adoption process?

- What are the perceived similarities and differences between adopting a child from Eastern Europe and within the United States?

- What advice would participants give to families planning to adopt a child from Eastern Europe?

The answers to these questions provided information about the experiences of families who have chosen to adopt a child from Russia or Romania. It is my hope that this information will help prepare other parents planning to adopt; educate mental and medical health professionals on how they can better serve this population; and that the study will have served as a worthwhile experience for the participants. I chose to review the literature of three main areas: collaborative health care, raising special needs children, and international adoption. By providing literature reviews on these three topic areas, I provided a context for my focus in this complex area of study, and a basic knowledge base from which to understand the families' answers to my research questions. Key words that I used to search the literature included: medical family therapy, mental health in medical settings, international adoption, adoption, special needs parenting, special needs children, Eastern European adoptions, collaborative health care, family

therapy and medicine, collaboration in health care, mind-body connection, and medicine and families. I used three comprehensive databases for my literature search: Psychlit, Family Studies Database, and Medline.

CHAPTER II: LITERATURE REVIEW

Upon initiating this study, I formulated my interviews as they were firmly grounded in two research literatures. I present them to you from the larger to the smaller system, or from societal to family perspectives: the collaborative healthcare team's efficacy in incorporating medical family therapists to a family perspective of internationally adopted children's risk for both medical and psychosocial problems.

Collaborative Healthcare

Collaboration among health professionals. Traditionally, psychotherapists have received little to no training in human biology, whereas, medical doctors have received little to no training in psychological aspects of human life (McDaniel, Hepworth, & Doherty, 1992). Despite the lack of training that professionals receive, in recent years several researchers have striven to bridge the gap by investigating the connection between psychological distress and unexplained physical symptoms (Sapolsky, 1998; Katon, 1995). However, the systemic connection between relationships and health has only very recently begun to be understood by medical family therapists and researchers. Rolland (1994), a prominent health care researcher, defined medical family therapy (MMFT) as a unique approach toward holistic and ecosystemic thinking, uniting mind and body of the individual, client family, or patient. In addition, McDaniel, et al. (1992) defined MMFT as the biopsychosocial treatment of individuals and families who are dealing with medical illnesses. As this important field has developed over the past twenty years, research has increased our knowledge of the relationships between family, health, and the mind-body connection (Campbell & Patterson, 1995). Efficacy research is an important way to evaluate and inform the development of a new professional arena. Since medical family therapy is still a discipline in its infancy, only a few empirical studies directly evaluating MMFT efficacy have been reported. However, there have been many studies examining the impact of collaboration between mental health care professionals and medical doctors on treatment outcome. Therefore, I would like to review the effects and outcomes of the incorporation of medical family therapist into health care teams.

A number of studies have examined how mental health treatment can affect utilization of medical services. Although most has focused on adults' medical utilization, a few of these studies have examined the effects of mental health treatment on children's health care utilization. Graves and Hastrup (1981) studied how psychological intervention affected medical utilization

in children and adolescents. The treatment group received psychological services while control group one was matched to the treatment group by sex, age, and ethnicity, as well as previous medical utilization and psychological distress. Control group two was matched to the treatment group only by age, sex, and ethnicity. The results demonstrated that the treatment group used the medical services less than either control groups. Finney, Riley, and Cataldo (1991) evaluated ninety-three children (ages 1-15) with common behavioral problems, toilet training difficulties, school issues, and psychosomatic problems and found that children's use of medical services was reduced during the year after mental health treatment. Despite these encouraging findings, Kelleher and Starfield (1990) did not find a relationship between mental health care access and medical service utililization, nor did access decrease symptoms of physical illness. As a result, there is much need for future research examining the complex relationships between mental health care and medical symptoms and services accessed.

Medical family therapy effectiveness. A limited number of studies have examined medical family therapy effectiveness in particular. However, even these studies lack a clear and consistent definition of what 'medical family therapy' is or includes. Gustaffon, Kjellman, and Cederblad (1986), compared a treatment and control group of children with a diagnosis of severe, chronic bronchial asthma. The treatment group received family therapy while the control group received no treatment during the study. Results indicated that there was greater improvement in the treatment group than in the control group as measured by the pediatric assessment, clinical grading, peak expiratory flow, days with functional impairment, and number of inhaler doses during the day and night. The control group, who received routine medical treatment, demonstrated no significant improvement in asthma symptoms.

Another study examined the views of referrers and clients towards marriage and family therapy (Graham, Senior, Lazarus, Mayer, & Asen, 1992). Seven general practitioners and twenty clients filled out surveys that examined their satisfaction with the level of care received by clients from marriage and family therapists. Researchers reported a high satisfaction among general practitioners (90%). In addition, 80% of the clients/patients felt that their problems (physical and mental) had improved at the time of follow up. Also, in the group of clients who did not feel like their problem had improved, 60% reported that they were at least dealing with their problem better.

Individual therapy has been compared with family therapy in treating patients with medical illnesses. One study examined the impact of family therapy versus individual therapy for adolescent females with anorexia nervosa (Robin, Siegel, Koepke, Moye, & Tice, 1994). Twenty-two adolescents and their parents participated in the study and received approximately 16 months of outpatient therapy along with routine medical and nutritional treatment. The addition of family therapy produced a greater change in participants' body mass index than individual therapy alone. However, there was no difference between groups in eating attitudes, body shape dissatisfaction, interceptive awareness, depression, or eating-related family conflict over the 16 months of the study.

Campbell and Patterson (1995) reviewed the literature assessing how effective family interventions are in the treatment of physical illness. They reported that family functioning has a powerful influence on physical health but that the empirical evidence for family interventions on physical illness is less conclusive. Family therapy appears to be most effective in treating childhood disorders such as asthma and diabetes. In addition, Campbell and Patterson reported that family therapy appears to be effective in treating cardiovascular disorders, neurological disorders and obesity. The same researchers also report that family therapy is more effective in treating anorexia nervosa than individual therapy. As a result, Campbell and Patterson conclude that medical family therapy plays an important role in the health care system.

Parental expectations for their children are a potentially rich area for family therapy. On study examined mothers' reflections on supports needed from the time they received a prenatal diagnosis of Down Syndrome until the birth of their child (Helm, Miranda, & Chedd, 1998). The researchers examined how the diagnosis was initially presented to the mother/family, the decision to continue the pregnancy, and the mothers' experiences with professionals from diagnosis to delivery. These processes are analogous to the adoption processes of finding out that an adoptive child will have special needs, the decision of whether to continue with the adoption, and the parents' experiences with health professionals throughout the adoption process. Helm, Miranda, and Chedd (1998) reported that 1) all of the mothers remembered with great clarity how the news that their child had Down Syndrome was delivered to them and highlighted the great need for health care providers to be helpful during this overwhelming time; 2) the majority of mothers highlighted the importance of support from family and friends during the process of deciding whether or not to continue with the pregnancy; and 3) several of the mothers

reported negative and positive experiences with health care providers throughout the diagnosis to delivery process. Some negative experiences with the health care system included: 1) health care providers assumed that mothers would want to terminate their pregnancy; 2) health care providers assumed that mothers could not handle the news; 3) providers did not give the prenatal diagnosis in person, and 4) technical staff were cold or distant throughout the examinations. Some of the helpful interactions reported by participants were that the health care providers gave them adequate and detailed information and were willing to meet with them via phone or in person to discuss options and answer further questions. While this study examined parent perspectives when learning of a known diagnosis (Down Syndrome) with uncertain outcome, preadoptive families are often presented with much more uncertainty of diagnoses and health care providers with less understanding of what may lie ahead for a given child. The current study attempts to provide support for health care professionals collaborating with one another to better meet the needs of their patients/clients. As existing research documents that children with a history of institutional living will have more medical problems, this study offers a better understanding of the psychosocial and familial impact of these stressors. In addition, this study suggests what health professionals can do to support families through the adoption process.

International Adoption

For many decades, child development researchers have reported harmful effects of institutional living (Bowlby, 1951; Chapin, 1915; Rutter, 1995). Some of the social and biological risks include: Increased morbidity and risk for infectious diseases; delays in growth and nutrition; impairments in cognitive development; difficulties in social and affective development; and physical and sexual abuse (McGuinness & Pallansch, 2000). In summary, if children are institutionalized, no matter how clean or adequate the conditions are, they are at increased risk for being psychiatrically and emotionally impaired as adults (Frank, Klass, Earls, & Eisenberg, 1996).

Medical risk factors. The majority of research examining international adoptees and their families has focused on medical risk factors related to institutional living. In taking a holistic approach to health care, it is important to review these findings because medical problems play a role in the psychosocial well-being of adoptees and their families. Over the last ten years, the physical conditions and psychosocial welfare of international adoptees have declined considerably, perhaps related to decreasing standard of living and increasing percentage of

children residing in orphanages in the countries from which children are being internationally adopted (Johnson & Dole, 1999; Federici, 1999). Conditions increasing a child's risk for long-term medical and developmental concerns that have been frequently reported in this population include: low birth weight (the number one risk factor for childhood morbidity and mortality); Fetal Alcohol Syndrome (FAS); growth failure; developmental delays (gross and fine motor, language and social/emotional skills) ; microcephaly [1]; feeding disorders; congenital syphilis; lead poisoning; anemia; and sleep disorders (Johnson & Dole, 1999; Miller, 1999).

Over the past decade, reports in the literature have confirmed that children adopted from Eastern Europe and the Former Soviet Union present with a number of medical risk factors that may either impact on or directly correlate with future medical, developmental or mental health concerns. While living in an institution, Johnson, et al. (1992) reported that infants' heights, weights, head circumferences, and weight-for-height ratios were adversely affected by institutionalization. Another study that examined the health of children adopted from Romania found only 15% to be physically healthy and developmentally normal (Johnson, Miller, Iverson, Thomas, Franchino, Dole, Kiernan, Georgieff, & Hostetter, 1992). In fact, 53% were found to have a past or present hepatitis B infection; 33% of the subjects had intestinal parasites, and 45% of the infected children had two or more pathogens. One study that examined children adopted from the former Soviet Union and Eastern Europe reported that 91% of the children had one or more growth delays, developmental delays, or other serious medical conditions (Albers, Johnson, Hostetter, Iverson, & Miller, 1997). Johnson (1997) reported that 50% of the children in his study who were adopted from Eastern Europe were low birth weight infants, many were born prematurely, and/or some were exposed to alcohol in utero. Johnson and Dole (1999) reported that out of 252 sequential referrals of infants from Eastern Europe that been evaluated by their clinic, 48% had low birth weight; 16% were diagnosed with Fetal Alcohol Syndrome, and 23% had neurological or medical problems such as chronic hepatitis B or C, cerebral palsy, autistic-like behaviors, and severe microcephaly. In contrast, normal growth development could only be confirmed in 9% of the children.

Although my study considers specifically children adopted from Russia and Europe, similar risk factors have been reported for children adopted from many countries. For example,

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[1] Microcephaly is a condition in which the head is very small. Infants with microcephaly often survive but tend to be mentally retarded and lack muscle coordination.

Miller and Hendrie (2000) examined the health of children adopted from China and found that growth and developmental delays were frequent among the 452 internationally adopted children who participated in their study. Thirty-nine percent of these children experienced growth delays for height, 18% in weight, and 24% for head circumference. In addition, gross motor delays were found in 55% of the children, fine motor delays were found in 49%, cognitive delays were found in 32%, and language delays were found in 43% of the children. Similarly, McGuinness, McGuinness, and Dyer (2000) examined children adopted from the former Soviet Union in their sample and reported that many of the children had a history of low birth weight, and 41% of their birth mothers abused alcohol.

In addition to the known risk factors at the time of adoption, children may have pre-existing medical concerns at the time of adoption. For example, children may have been placed in an institution/orphanage initially because they had major medical problems or physical handicaps and parents were unable to access resources to help them. Johnson (1997) reported that other studies have shown that more than 50% of internationally adopted children have an undiagnosed medical problem at the time of first evaluation in the United States regardless of age, sex, or country of origin. Although different percentages have been reported across studies, all of them found high percentages of the internationally adopted children to have serious medical conditions.

The known and unknown risk factors that may be present with any internationally adopted child have implications for adopting families. On the other hand, most of these children appear healthy and make substantial developmental progress from the point of adoption to the time of their first visit to a health care provider. Most parents are prepared to adopt a 'healthy child' and often new adoptive parents are unprepared for the challenges that they would probably face as a result of their child's medical problems (Johnson, 1997; Federici, 1999). It has been suggested that careful developmental and growth screening needs to be implemented at the time of adoption in order to provide early intervention and appropriate treatment (Federici, 1999; Johnson & Dole, 1997; Miller, 2000; Miller, Kiernan, Mathers, & Klein-Gitelman, 1995).

Psychological and neuropsychological risk factors. Along with the medical risk factors that have been widely reported in children who have lived in institutions, a wide array of psychological and neuropsychological risk factors may contribute to the development of behavioral, emotional, or cognitive problems for these children (Johnson & Hostetter, 1997;

Federici, 1999). There has been a discrepancy in the findings regarding the impact of long-term effects of institutionalization on psychological well being of children. Some studies have concluded that there is not a significant difference between adopted children and biological children in the areas of emotional, cognitive and behavioral development (Bagley, 1992). Yet other studies find that adopted children who have lived in institutions fare much worse in most arenas than their non adopted counterparts (Federici, 1999; Johnson, 1999; Miller, 2000). Studies examining the long-term effects of institutional living on children are necessary to provide researchers and clinicians with a better understanding of what these children and families may face. The following studies have attempted to describe the special needs and problems this subpopulation may encounter.

Federici (1999) reports that although attachment disorder in post-institutionalized children has been discussed to a large extent in the literature, researchers are lacking a comprehensive understanding of attachment disorder's[2] etiology and effects in this population. Federici suggests that the concept of "neuropsychological-based attachment disorder," which recognizes the interplay between medical, prenatal, and post-natal factors, in addition to the abandonment and absence of caregivers that may contribute to attachment disorder symptoms in this population of children. In fact, Johnson and Dole (1999) report that there is an observed interplay between growth parameters and neurological competence in extremely deprived institutional children assessed in Romanian institutions, with growth delays correlated with a decrease in neurological competence.

Children who have lived for a period of time in an institution may present with autistic-like behaviors. While some of these children most likely have neurogenetically-based autism[3] or mental retardation, other children's patterns of autistic-like behaviors as research has suggested may be atypical and related to institutionalization (Federici, 1998). Some of the characteristics of this "atypical autism" may include: 1) loss of weight and failure to gain height in the absence of a neurological disorder; 2) lack of characteristics that make a child's age and sex easily recognizable; 3) lack of language progression with a history of developmentally appropriate language usage; 4) display of primitive behaviors due to institutional trauma, nutritional and

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[2] Attachment disorder- markedly disturbed and developmentally inappropriate social relatedness in most contexts, beginning before 5 years of age (American Psychiatric Association, 1994).
[3] Autism- qualitative impairment of social interaction and communication as well as restricted and repetitive patterns of behavior (American Psychiatric Association, 1994).

medical neglect, self-stimulating behaviors, attachment to others with similar characteristics versus healthy and normal human attachments; and 5) improvement in symptoms following removal from traumatic situation (Federici, 1999). Atypical autism is not the only concern for these children, with several serious psychological and neuropsychological problems reported in studies examining post-institutionalized children including: attention deficit disorders, learning disabilities and weaknesses, sensory integration issues (Federici, 1999; Fisher, Ames, Chisolm, & Savoie, 1997). These findings suggest   researchers and clinicians should know how psychological and developmental abnormalities, including atypical autism, may develop and present in and later impact the cognitive, emotional, and interpersonal abilities of post-institutionalized children.

Family experiences. While there is little research examining child outcomes after adoption from Eastern Europe, even fewer studies have looked at the family functioning as a whole after adoption (Price, 2002). I will review six studies that have attempted to observe family outcomes of adopting a child internationally.

Groze and Ileana (1996) examined the positive and negative aspects of adopting children from Romania while paying particular attention to the experiences of families who adopted a child from an institutional setting. They found that a significant number of the families were considered to be at risk because they had not had adequate preparation for the adoption. These researchers purport that successful outcomes depend more on the parental and family characteristics than on the child.   Adequate preparation for the adoption process reduces the risk for negative adoption outcomes (Barth & Berry, 1988). In addition, Groze and Ileana (1996) found that participant families reported that adoption agencies/individuals were either unhelpful or unresponsive post-adoption and that the community lacked people who could help them deal with issues after their adoption.

Mainemer, Gilman, and Ames (1998) examined parenting stress in families adopting children from Romanian orphanages/institutions. Predictors of parenting stress after adoption included aspects of the child's behavior, such as attachment security and behavioral problems, as well as family factors such as income, number of Romanian children adopted, and the mother's age. However, the strongest predictor of parenting stress was child behavioral problems.

Looking from a behavioral, rather than a neurological, perspective Hoksbergen (1997) compared internationally adopted children to non-adopted children. First, there were higher

percentages of problem behaviors among adopted children (see also, Marcovitch, et al., 1997). Second, placement in residential programs and institutions was more frequent with adoptees. Third, higher percentages of adoptive parents stated that they needed assistance in dealing with the behavioral problems of their adopted children. Higher percentages of adopted children had contact with police and the court system. Finally, more adoptive children had educational problems and required special education.

The first study to examine international adoptive family environment with standardized measurements examined competence levels of children adopted from the former Soviet Union (McGuinness & Pallansch, 2000). For purposes of this study, 'expressiveness' was defined as the extent to which family members were encouraged to talk about their feelings openly and 'cohesion' was defined as the degree of commitment, help, and support family members provide for one another. 'Competence' was operationally defined as a pattern of effective behavior at home and at school. Among the sample, competence levels ranged from challenged to developmentally normal. The length of time spent in the orphanage was inversely related to competence outcomes. In addition, findings suggested that the positive family environment served as a more significant protective factor than socioeconomic measures of success. Family cohesion and expressiveness were significantly positively related to higher levels of child competence. Goldberg (1997) explored the experiences of eight mothers who had adopted Romanian children. Although this article did not explore post-adoption family experiences, it did attempt to understand their experiences throughout the adoption process. The eight mothers had varying adoption experiences related to the year the adoption occurred and the restrictions placed on the adoptions at that time. Some parents were able to adopt easily on their first attempt whereas others' had adoptions that were not able to be completed up to five times before they were able to bring home a child.

In 2002, Patti Price, the education chair of Families of Russian and Ukrainian Adoption (FRUA), conducted a study that examined both child and family outcomes of adoption. Surveys were mailed to the 108 members of the FRUA family support group that agreed to participate in the study. Information was gathered about the following content areas: Social support from families and friends; parenting stress; family flexibility and cohesion; and stress from the adoption process. Support from friends was reported to be quite high and after the adoption was complete, friends were also considered more supportive of the adoptive families' experiences

than the extended family. Overall, parents who had experienced infertility and pursued extraordinary means, such as in vitro fertilization, experienced significantly more adoption related stress than those who did not go through extraordinary means or adopted for reasons other than infertility.

After reviewing the research on the medical risk factors, psychosocial risk factors, and families' experiences with children who have been adopted from institutional environments, I would like to highlight that no studies have simultaneously examined or considered the interplay of these three aspects of the adoptees' lives. One aim of my study is to elicit and describe information about   all three aspects of the adoptees' and their families' experiences.

CHAPTER III: METHODS

Creswell (1998) suggested that with qualitative research it is appropriate to research questions that start with a *how* or *what*. To explore how international adoptive parents' expectations compared with their experiences and how they experienced health care services post-adoption, I used qualitative phenomenological methods.

Phenomenological Methods

As with most qualitative methods, phenomenological methods achieve research quality through developing a thick description of the participants' experiences and then drawing meaning from their words. The researcher serves as the primary instrument and collects data through observations, interviews, and documents (Merriam, 1998). The aim of phenomenological research, which originates from the idea that human experiences make sense to those who live the experiences, is to examine the meaning of participants' experiences (Creswell, 1998). Furthermore, in phenomenological research, the purpose is not to search for measures with validity, as is important with quantitative research, but rather to provide subjective relevance and an adequate description of the experiences (Sprenkle & Moon, 1996).

 I used triangulation as a method for establishing data validity and my focus was to accurately describe the participants' experiences. Triangulation was achieved via simultaneous data collection via parent interviews, observations, and field notes. Sprenkle and Moon state, "given the complexity and diversity of the experience of a particular family, phenomenological research is more interested in accurately reflecting a given family's experience than generalizing to families in general" (p. 92). Therefore, the main focus of this study was to provide thick description of these families' experiences.

According to Sprenkle and Moon (1996), the phenomenological researcher should attempt to extend the family's natural conversation, which is already taking place, and help them to construct meaning. Furthermore, they contend that phenomenological research can be viewed as having two levels: Family's constructions from their every day world and the researcher/family's constructions of meaning and interpretations. The researcher is most interested in the creation of stories from the meanings and interpretations. In order to verify that my interpretation of the interviews and observations was congruent with the participants' experiences, I used the technique of member checking by sending participants a copy of the initial themes and a return stamped envelope following the first in-depth interview to allow them

to clarify meanings, comment on findings, and participate in further data collection (Sprenkle & Moon).

An important aspect of research using this method of data collection and analysis is acknowledging that reality is what people imagine or perceive it to be. Douglas (1985) signifies the importance of these subjective views when he states that internal ideas, feelings, and motives are important and meaningful because they make up the essence of humans, separating us from basic living organisms. As a research method, phenomenology can employ numerous methods of data collection, including observation, loosely structured in-depth interviews, and journal entries. The data can be analyzed using constant comparative method to form a conceptualization of the experience and its dimensions. Given that this study was descriptive in nature, phenomenological methods attempted to capture participants' experiences and help create meaning and stories to the experiences. To this end evolved organizing the themes that emerged from the participants' stories, incorporating my observations via field notes and my research journal, and reflecting on the literature. Hence, the interpretations that emerged allowed me to place the participants' stories, my observations, and the existing literature into a new, broader story that will provide new knowledge for families and professionals alike.

Pilot Study

For partial requirement in a qualitative methods course, I completed a pilot study using a preliminary interview guide with four parents who had adopted children from Russian institutional settings. A pilot study allows researchers to experience the possible changes throughout the interview as well as to develop their sense of a researcher-participant relationship (Seidman, 1998). This was a valuable process for me to go through before conducting my dissertation study. In addition, Seidman states that pilot studies help researchers to better understand whether their research structure is adequate. Upon the completion of my pilot study, I was able to reflect and learn about the interview process as well as slightly modify my interview guide based on what I had learned from my pilot study participants.

Not only did the pilot study help me sharpen my interview skills and adapt my interview guide, it also allowed me to gain additional experience in thematic analysis. From coding and discovering emerging themes in the data, I developed an even stronger passion for understanding participants' stories of adopting a child from an Eastern European institution. This passion has kept me motivated throughout the research process.

Data Collection

<u>Population and Sample.</u> A minimum of twenty families were selected from a group of 1500 families who sought neuropsychological consultation because of emotional, behavioral, cognitive or emotional concerns with their adoptive children and from self-selected members of FRUA (Families for Russian and Ukrainian Adoptions). All participants had received a mental health and/or medical evaluation prior to their participation in this study. A clinical sample was chosen because these families had sought health services and therefore could answer the research question on how adoptive parents experience health care services post-adoption. These participant families had adopted one or more children internationally from either Russia or Romania. Essential criteria for research participants were that the age of the child at adoption must have been between 3 and 5 years of age, the parent(s) must be the child's primary caregiver(s), and they must have adopted the child at least one year prior to participation in the study. Participants also needed to be willing to participate in one long interview as well as a follow-up interview (if needed) and give me permission to audiotape the interviews. Therefore, the sampling technique was purposive criterion sampling.

One group of participants had children who were evaluated by their attending neuropsychologist, Dr. Ronald Federici, who introduced the participant families to the study. Dr. Federici made it very clear that agreeing to being contacted by the researcher was not related to receiving services and that even if the family consented to being contacted by the researcher, he would not know if they chose to participate in the study (see appendix A for a copy of the introduction protocol).

A second group of participants were contacted by FRUA's Board of Directors' representative, Mara Kamen, through internet channels, and given an introduction to the research project and asked if they wanted to participate. Those who did want to participate sent their 'agreement to participate' through an e-mail to Mara Kamen. At that time, I contacted the willing participants.

<u>Invitation to Participate and Confidentiality.</u> Families were contacted initially by phone or e-mail. Family selection was based on participants' willingness to be interviewed and observed. I called or e-mailed them to introduce the topic and purpose of my study, send an invitation packet (appendix B) and arrange a time to talk with them again after they had time to read the packet. Next, I reviewed an informed consent (appendix C) with them, asked if they

were willing to participate, and set up a time to interview them in person. The majority of the interviews took place in Northern Virginia since the participants were mostly living in that area. However, two participants were interviewed in Wisconsin and two were interviewed in Richmond, Virginia. Each of the participants was given a confidential pseudonym.

Interviews. This was a qualitative study conducted for the purpose of understanding how adoptive families have experienced the adoption process. Performing the interviews with the parents allowed them to more fully share their stories than a close-ended method such as a survey. Also, face-to-face conjoint interviews provided the opportunity for participants to co-construct a new or deeper meaning of their experiences. I conducted 20 face-to-face in-depth interviews with participants and field notes were recorded following each interview. In addition, I kept a research journal throughout the entire research study.

An in-person interview of approximately 60-130 minutes was the method through which data were collected in this phenomenological research. At the beginning of the first interview the participants were asked to read and sign the consent form (Appendix C) after I repeated the discussion from our telephone conversation about the purpose of the study, confidentiality, and their right to withdraw at any time. Both copies were signed and one copy was given to the participant and one was kept with my records. I requested that they choose a pseudonym that would be used throughout the dissertation and any possible publication or presentation of this material in order to protect their privacy. I selected a few of the pseudonyms for those who preferred that I select a confidential name for them and for those who forgot to select names during the interview.

Phenomenological interviewing is a specific type of interviewing that requires the researcher to "enter into the field of perception of participants" (Creswell, 1998, p. 31). As Seidman (1991) states, "At the heart of interviewing research is an interest in other individuals' stories because they are of worth" (p. 3). While I conducted in-depth interviews, I was making observations on the body language of the participants as well as their interactions with family members who were present at the interview. The semi-structured interview guide that I constructed is Appendix D.

I established an interview situation that attempted to create a safe space for the parents to reflect on and interpret their experiences, rather than simply report them (Chase & Bell, 1994). One way that I was able to accomplish this rapport was to allow participants to choose the

location where they wanted the interview to take place. All but four participants chose to have me come to their homes. I met the other four participants at their place of work or the gatekeeper's office. Several participants shared with me that they felt more comfortable being open and sharing their experiences in their homes. I made the interviews conversational and open-ended and I accepted and supported disclosures and clarifications that participants made as we progressed. I emphasized the importance of self-reports so that the research participants understood that their contributions would provide an illumination of meanings and were valued as new and important knowledge. In addition, I made the phenomenological interview as informal and interactive a process as possible to increase comfort of participants. I believe that I accomplished the task of creating a safe place for participants in order for them to feel comfortable because all of the interviewees were very open about their experiences and the majority said that they appreciated the chance to share. One participant gave me a book that she had found particularly helpful throughout her struggles with her son and fourteen of the twenty participants asked to show me pictures of their child (ren) and the orphanages. I took these behaviors as cues that participants felt comfortable with me.

Field Notes. I recorded field notes after the completion of each day of interviewing to ensure that my observations about the environment and participants would not be forgotten (Strauss & Corbin, 1990). Upon the completion of several interviews at a time, I compiled a list of summary notes outlining what I felt were the most important points to remember. These were typed verbatim and used to guide my thinking when I was developing my coding scheme and analyzing my data.

Research Journal. Throughout the research process, I recorded information about my personal reactions to the study in my research journal. I included thoughts, questions, and feelings that I had about the research process in general as well as things that had touched me about participants' stories. Throughout the study, many memories resurfaced of my time spent in the Romanian institutions in the summer of 2001. By recording these thoughts and feelings in my journal, I was able to gain a better understanding of my role in the research process and of how my life experiences affect how I interpret participants' words. While transcribing, analyzing, and organizing the data, I frequently returned to my research journal to read what I had written and think about how it pertained to the participants' words. I included sections from this journal throughout my results and discussion sections.

Data Coding and Interpretation

      I conducted twenty interviews within a period of four months. Each interview was audio taped and transcribed verbatim. I transcribed twelve of the interviews myself and paid a transcriptionist to transcribe the remaining eight. For the interviews that I did not transcribe myself, I listened to the tapes and reviewed the transcripts to check for accuracy. I was able to make changes to the electronic copies of the transcripts and clarify information that the transcriptionist found inaudible. After all the transcriptions were accurate and complete, I printed two hard copies of each transcript. I saved one copy of each transcription in a secure location and used the other copies for data analysis.

      I offered a second interview to all participants in order to discuss a summary of my findings. I also encouraged all participants to review my findings and discuss them with me. Research participants were given the opportunity to review and confirm or alter the research data to correspond to their perceptions of the experience. This also allowed me the opportunity to ask participants follow-up questions. I conducted follow-up interviews with five participants via phone and e-mail in which I actually asked clarifying and/or follow-up questions. This form of concurrent data collection and interpretation is called the constant comparative method and is at the heart of several methods of qualitative research. Initial analysis consisted of a process of coding, thematic analysis, and thematic building. Thereby, interpretation was not necessarily viewed as a distinct stage of the research process, but rather an interwoven reflexive process that informed the data collection (Coffey & Atkinson, 1996) as it began as soon as I heard the first interview and continued throughout the writing process through my constant immersion in the participants' stories, the literature, and my experience as the researcher.

      To begin the coding process, I read the transcripts of each interview the first time to gain an overall impression of the content. During the second reading, I wrote code words in the margins that I thought captured the participants' thoughts, patterns of behaviors, and phrases. While undergoing this process of open coding, I kept in mind the research questions and theoretical perspectives guiding my research. To ensure trustworthiness of my findings, two of my colleagues each cross coded 2-3 interviews. I had a separate meeting with each colleague and we compared initial codes that we thought had emerged from the interviews. At this point, I developed a coding scheme. The first coding scheme consisted of 13 themes and 71 sub themes (see Appendix E). Through suggestions from one of my cross coders and a committee member, I

was able to collapse themes and sub themes so that my coding scheme was more succinct. The final coding scheme, eighth draft, consisted of 4 themes with 26 sub- themes (see Appendix F). As I read the transcripts for a third time, I sought all possible frames of reference about the adoption process experience as well as the meaning the participants made of their experience and used the coding scheme to code the data. I highlighted the themes and wrote coding numbers next to the sub themes within each of the transcripts. Next, I compiled the list of all participants and compared responses across participants. At this point, I listed the themes that seemed most significant to the research questions of this study and tried to get an overall description of their adoption experiences. Then, I sent this list of themes to the participants in my study to ensure that they agreed with my interpretation of their experiences.

Role of Researcher

As mentioned earlier, my role as the researcher was to interact with the participants. In concordance with obtaining data from participants, qualitative researchers also believe in the importance of developing a relationship with them (Rossman & Rallis, 1998). By providing a comfortable, safe environment for participants (Chase & Bell, 1994), I was better able to understand and elicit details of their experiences. During my pilot study, I found the process of interviewing participants and developing a relationship with them to be congruent with intake sessions in my clinical work as a marriage and family therapist. These processes seemed similar to me because I used the same avenues for interacting with the participants, ensuring their comfort, and being empathetic toward their experiences. Furthermore, one of the reasons that qualitative inquiry seems like a good fit for my research interests and lens is that I believe it is consistent with the therapeutic process. One of the drawbacks of this congruency is that I needed to learn to set different boundaries with participants than I do with clients because my responsibility and roles of a researcher are different than those of a therapist. For example, as a researcher, I was responsible for ensuring that participants were not harmed from participating in the research project and for proving them with numbers and contacts for services and resources that can help them. However, I did not want to become a therapist to them. Throughout the research process, it was extremely helpful for me to create and use my own field notes and research journal entries because it allowed me to recognize my own voice in the research. I did not try to take the role of an objective researcher with no connection to the participants or the phenomena under study. I was able to be the researcher as well as a participant in the process.

CHAPTER IV: FINDINGS

In this study, I explored the experiences of families who adopted a child or children via: Face-to-face, in-depth interviews with 20 participants; constructing field notes; and maintaining a research journal. I designed the research study to solicit information from the participants that would inform future potential adoptive families and enhance health professionals' understanding of the complex experiences of parents who have adopted a child from a Russian or Romanian institution.

As I read, coded, and discussed the data with committee members and colleagues, I developed a comprehensive understanding of the data. From this understanding, themes emerged. Four main themes emerged that illustrate the experiences of these parents: (A) experiences of adoption process, (B) family metamorphosis, (C) child characteristics, and (D) social response to adoption. Some of sections are descriptive in nature (e.g. services provided, diagnoses of children) and only need a few direct quotations from participants to illuminate their meaning, while other themes and sub themes are more complex and descriptive of specific experiences and perspectives, and thereby several in-depth quotations from participants are provided for an adequate description. However, before introducing the thematic results of the interviews, it is important to meet the 20 participants in this study—for theirs are the stories that will be presented.

Introduction of the Participants

Most of the interviews took place in Northern Virginia, and four interviews took place in Central Virginia or Wisconsin. All but four interviews took place in the homes of the participants. The other four interviews took place at the participant's work place, a nearby coffee shop, or the gatekeeper's [Dr. Ronald Federici] office. All participants had adopted children from either Russia or Romania who had lived in an institutional setting prior to their adoption. The adopted children have been living with the participants for a time period ranging from one year to ten years. All of the participants were of middle to upper socioeconomic status. Before presenting the findings, it is important to first introduce the participants in this study. There were twenty families that participated in my study and so I will introduce them by the order in which I interviewed them.

Pseudonyms were chosen to protect the identity of each participant. Participants were asked at the beginning of the interview process if they could think of a pseudonym by which they would like to be referred to throughout the findings and discussion section of the dissertation. No participants chose their own pseudonym and therefore, all of the pseudonyms were assigned to participants randomly. The first section in this chapter, context, provides information on each participant by pseudonyms

Table 1

Description of Participants

Pseudonym	Marital Status	Place of Residence	# of Children	Race
Cindy & Lindsey	Lesbian Partnership	Central Virginia	1	Caucasian
Jean	Married	Central Virginia	2	Caucasian
Linda	Married	Northern Virginia	2	Caucasian
Barbara	Married	Northern Virginia	1	Caucasian
Louis	Single	Northern Virginia	2	Caucasian
Wanda	Single	Wisconsin	1	Caucasian
Sheila	Single	Northern Virginia	2	Caucasian
Pat & Tayna	Separated	Northern Virginia	2	Caucasian
Laura	Married	Northern Virginia	3	Caucasian
Margo	Married	Northern Virginia	4	Caucasian
Keesha	Divorced	Wisconsin	3	Caucasian
Pete & Stacey	Married	Maryland	2	Caucasian
Erica	Single	Northern Virginia	5	Caucasian
Ursula	Separated	Northern Virginia	2	Caucasian
Pamela	Married	Northern Virginia	4	Caucasian
Amy	Married	Maryland	1	Caucasian
John & Melinda	Married	Northern Virginia	1	Caucasian
Mary	Lesbian Partnership	Northern Virginia	3	Caucasian
Ron & Becky	Married	Northern Virginia	2	Caucasian
Christine	Married	Northern Virginia	5	Caucasian

Cindy and Lindsey are a middle-aged, Caucasian, lesbian couple who adopted a little girl from Russia in February of 1998. Therefore, their adoptive daughter has been living with them for five years. They have no other children. Lindsey is employed outside of the home full-time and Cindy is a self-employed artist. They live in central Virginia. There were four dogs and two cats also living in the house, all of which had been rescued by them through Animal Rescue.

Jean is a middle-aged, Caucasian, married woman who adopted a three-year-old girl from Kirov, Russia. She and her husband also adopted two children domestically prior to adopting from Russia. They have been married for sixteen years. I interviewed Jean in her home just before she and her family were leaving for their Christmas vacation. She was very welcoming and was excited about sharing pictures of the orphanage and their first days with their daughter.

 Linda is a middle-aged, Caucasian, married woman who had adopted a 23-month-old boy and a 3.5-year-old girl from Russia in 1996. Both of the children have been living with Linda and her husband for about five years. She is at home full-time and she feels she needs to be with her children in order to meet their special needs. She fills a room with energy and spirit and seems to have a great passion for talking about her children.

Barbara is a middle-aged, Caucasian woman who lives with her husband and one adoptive child from Russia. Their adoptive son was 15-months-old when they adopted him and he has been living with them for about 5 years. After the adoption, she cut her work schedule from full-time to part-time in order to ensure that her son receives all of the services he needs. After the interview was over, all three family members showed me pictures of the orphanage and the family's first experiences together.

Louis, a middle-aged Caucasian man, lives alone with his two adopted Russian sons who were 3.5-year-old and 4.5-year-old when they were adopted. They were adopted from the same orphanage a few months apart, and although they are not biological siblings, they are considered "psychological siblings" because they grew up together in the same conditions. Louis has never been married and reports that he loves his family makeup and being a single father. Louis is a campaigner for a political party who volunteers his time to an international adoption agency that helps get older kids adopted. I interviewed Louis at the gatekeeper's office and we had to end our interview after 60 minutes due to his work schedule.

Wanda is a single, middle aged, Caucasian woman who lives with her adoptive daughter in Wisconsin. She adopted her daughter in January of 1997 from Timishora, Romania. Wanda

works part- time and they have one cat. Wanda is unsure about the chronological age of her daughter as the medical records from Romania are unclear. She guesses that she is about 11.5 years old. I interviewed Wanda at her work and we kept the interview to 60 minutes because we were talking during her lunch hour.

Sheila is a single, middle-aged, Caucasian woman who lives at home with her two adoptive daughters in Northern Virginia. She owns her own business. Her daughters were adopted from different orphanages in Russia. One was adopted in 1993 at the age of 3.5 and the other one was adopted in 1997 at 4.5. They are currently aged nine and ten respectively.

Pat and Tayna are a middle-aged, Caucasian couple living in two separate houses. They have been separated for one year, but they share custody of their two children. They have one biological daughter and they adopted their son from Russia in 2000. Their son is eight years old. Both Pat and Tayna are employed full-time outside of the home and they alternate taking care of the kids every week. I was able to interview both Pat and Tayna at Tayna's house, as well as eat dinner with the family beforehand.

Laura lives at home with her husband and three children. All three of her children were adopted from Russia in 1996. They adopted their daughter first but went back to Russia two months later to adopt their two sons. The boys are biological brothers, and, although their daughter is not a biological sibling to the boys, she was adopted from the same institution. Laura's husband works full-time and Laura stays at home full-time. Their sons are twelve and nine-years-old and their daughter is eight years old. Laura's husband was at work during the interviews so only Laura participated.

Margo and her husband are a middle-aged, Caucasian couple who have been married since 1993 and have four children. The oldest two children are from her husband's first marriage and together, Margo and her husband adopted two children from Russia in December of 1997. Their children are now eight and six years old. Their adopted daughter and son are not biologically related but are from the same institution. Both parents are employed outside the home. Only Margo participated in the interview.

Keesha is a middle-aged, Caucasian woman who lives at home with her biological son and two adopted children. She is divorced and has full custody of all of her children. They live in Wisconsin and the kids see their father infrequently. Keesha's biological son is in high school and her two adopted children are in elementary school. Currently, Keesha works full-time. I was

able to meet and interact with all of the children. Keesha's adolescent son talked with me about what it has been like for him throughout the pre- and post-adoption process.

Pete and Stacey are a middle-aged, Caucasian couple who have been married for twenty-four years. They adopted their son and daughter from Russia in August of 2001. The children were three and four years old at the time of adoption and were adopted from the same institution. They recently moved to Annapolis, Maryland. Both Pete and Stacey are employed outside of the home, but Stacey works only part-time. Pete and Stacey both participated in the interview and I was also able to meet their two children after Stacey picked them up from school.

Erica is a middle-aged, Caucasian, single woman who lives at home with her five adopted children from Romania. She has two adopted daughters and three adopted sons. The last two children whom she adopted in 2000 are biological brothers who were living in the same institution. The other three children were adopted from different institutions in 1991 and 1997. She and her children are getting ready to move to Sarasota, Florida. Erica is the chief operating officer of a company, but she works primarily from home.

Ursula is a middle-aged, Caucasian woman who lives at home with her two adoptive boys from Russia. They are biological siblings and were adopted from the same institution. She and her husband are going through a divorce, and he sees the boys sporadically for short amounts of time. Ursula is at home full-time. This was the second interview that Ursula participated in as she was also a participant in my pilot study. Only Ursula participated in the interview but I was able to meet and talk with her two sons.

Pamela is a middle-aged, Caucasian woman who lives at home with her husband and their four children. They have a biological son, who is seventeen years old, a daughter that they adopted domestically, who is eleven years old, and two adopted children from Russia, ages five and eight. The two children they adopted from Russia are not biologically related, but they lived in the same institution prior to their adoption. Pamela is at home full-time and her husband works full-time outside of the home. Only Pamela participated in the interview, although I was able to meet and talk with her children as well.

Amy is a middle-aged, Caucasian woman who lives with her husband of three and a half years. They have one adoptive son from Russia and are in the process of adopting a baby girl from Russia. They recently moved to Maryland and Amy is currently working from home full-time. Her husband is working full-time outside of the home. When they adopt their baby

daughter, Amy plans to take off work for about six months. Only Amy was able to participate in the interview.

John and Melinda are a middle-aged, Caucasian married couple who adopted a little girl from Russia in December of 2000. Their daughter is now seven years old. John and Melinda have been married for four years but have known each other for twenty years. Melinda is a nurse practitioner and John is a publisher. They both work outside of the home but Melinda has recently been working part-time. Both John and Melinda participated in the interview and asked me to join them for dinner afterward.

Mary is a middle-aged, Caucasian woman who lives at home with her partner and their three children. Mary has been in a committed relationship with her partner for fifteen years. They are both employed full-time outside of the home in highly demanding jobs although Mary can work from home when necessary. They adopted all three children from Russia. They adopted their first child ten years and two months ago while their other two children were delivered to Mary and her partner eight months later by a Russian government official. Only Mary participated in the 90-minute interview, which took place during her lunch break from work.

Becky and Ron are a middle-aged, Caucasian couple who live at home with their two adoptive sons. They live in Old Town Alexandria, Virginia and have been married for eleven years. Becky has one daughter from her previous marriage that is currently in college. Becky and Ron adopted their two sons, biological brothers who were then four and seven years old from Russia five years ago.

Christine is a middle-aged, Caucasian woman who lives at home with her husband of eight years and their two adopted children. Christine has three step children who do not live in their home. Christine and her husband adopted two children from Russia in February of 2001. Their two youngest children are ten and eight and a half years old. Both Christine and her husband are employed outside of the home. She is a teacher and he works for the military.

In summary, all of the participants in this study are middle-aged, Caucasian adoptive parents. Two of the participants adopted from Romania and the other eighteen adopted from Russia. Of the participants, eleven are married and two were in committed same sex relationships. Two participants are legally separated from their husbands, and two participants are divorced. Three participants are single and have never been married. The number of children adopted ranges from one to five.

Experience of Adoption Process

Given the amount of data that comes from qualitative interviews and observations, I have narrowed my focus to answering the research questions mentioned earlier in this paper. The following quotes and data represent themes and categories that emerged from the words of the participants.

Reason for Adopting Internationally versus Domestically

Participants listed multiple reasons for adopting internationally versus domestically. Some of these reasons included age of participants, family makeup, not wanting to deal with biological families, and the speed and ease of the international adoption process. Most participants were considered above the age range for adopting an infant from the United States, so they would have had to adopt a child from the foster care system. In addition, some participants were either single or in a same sex committed relationship and were also only approved for adoption from the foster care system. Several participants mentioned not wanting to have to deal with the biological families of their adopted children; this would not occur if they adopt internationally. They appreciated that adopting from Russia or Romania would be considered a closed adoption. Finally, some participants felt that it would be easier, quicker, and more cost efficient to adopt from Russia or Romania than it would be to adopt domestically.

When asked why they adopted internationally rather than domestically several participants referred to the fact that international adoptions can be closed. As suggested in the following statements, they did not want to face the uncertainty of a domestic adoption:

> To me, the major difference between international adoption and domestic adoption is domestic adoptions are usually open, whereas international adoptions are most often closed. There is no contact with the family in the international adoption situation, whereas there may be with domestic adoptions. Also, the time element to bring a child home is much longer in the domestic adoption. There could be a four year waiting list for infants and then the mothers can always go back and decide she wants to keep her child. It is just too uncertain. (Christine)

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We had looked into domestic adoption, and when we looked at it briefly, the fashion of

the day was for the birth families to be involved for five years. And I just hate the label of

adoption…..to me, they are my children and that should be the end of it. I pray for and

am grateful to the mother who gave up my children, but they are my children. (Laura)

Several of the participants also commented on the fact that they were older than the

allowed age range for adopting an infant domestically:

We were looking at adoption, and what we quickly discovered was that as far as domestic

adoptions, we were outside of the age window for a baby. So, there may have been some

leeway if we had wanted to adopt older kids or problem kids, but we did not. (Becky and

Ron)

There are differences. I looked for three years into adopting in the United States and the

only kids they would be willing for me to adopt, given my age and family makeup, would

have been physically, sexually, and/or emotionally abused children who had been in and

out of homes. (Mary)

Two of the participants had adopted both domestically and internationally and referred to

the ease of adopting internationally:

The main difference in my mind between adopting domestically [she adopted a

Caucasian infant] and internationally is that the process was just much easier. Our

experience with the court system in Russia was much more positive than it was in the

United States. (Pamela)

Difficulty/Ease of Adoption Process

Participants' responses regarding the difficulty/ease of the adoption process ranged from

the process being exceptionally easy to the process being exceptionally difficult. Much of this

discrepancy seemed to result from the year that the adoption took place, expectations that

participants had going into the process, and the adequacy of the agency, which will be addressed

in a later section. The following quotes are examples of statements from participants who found

the process fairly easy:

It was easier than expected once we found our children and went to get them [filed paperwork in   January of 1999 and chose children in September of 1999]. The trip was only eight days with no waiting period. The orphanage was better than expected, and we were able to spend five days with the children in the orphanage, and it was a fun, enjoyable, and stress-free time. (Christine)

Both adoptions were very straightforward. Contrary to what people have to go through today, my first adoption was three to four months and the second one was less time than that. Today, adoptions can take up to a year and a half. (Louis)

The adoption process itself was pretty easy. We had a good agency and a wonderful social worker and I think that makes a huge difference. (Melinda)

Whereas, here is an example of a response from a participant who felt that the process was more difficult:

There was a major glitch in my second adoption that made the process more difficult. After I given final notice at my job and bought my non-refundable ticket, complications began to develop with the child I was supposed to adopt. At first, there were suggestions that I spend longer in Russia to allow her to warm up to me. With my other daughter at home and my mother in none too stable condition; I could not spare a minute. Finally, a week before I was supposed to leave, they said that they feared that the little girl that I was supposed to adopt had autism and she was no longer adoptable. I was frantic and the agency did some frantic calls and found my youngest daughter who I adopted. (Sheila)

Adoption Characteristics

Under adoption characteristics, I listed seven categories consisting of the following: Age of child at adoption, length of time since adoption, length of time between decision to adopt and actual adoption, bringing child (ren) home, conditions of the institution, and child's preadoptive history. The responses to the first three categories of questions will be displayed in a chart, while the responses to the last three will be described through direct quotations from participants.

Table 2

Adoption Characteristics

Pseudonym	Age at Adoption	Length of Time Since Adoption	Length of Time Between Decision to Adopt and Adoption
Cindy & Lindsey	3.5 Years	5 Years	9 Months
Jean	3 Years	1.5 Years	5 Months
Linda	23 Months; 3.5 Years	6.5 Years	1 Year
Barbara	15 Months	4.5 Years	2 Years
Louis	3.5; 4.5 Years	3.5; 4.5 Years	3-4 Months
Wanda	5.5 Years	6 Years	8 Months
Sheila	3.5; 4.5 Years	6 & 10 Years	4-7 Months
Pat & Tayna	4.5 Years	3.5 Years	8 Months
Laura	5; 2; & 1 Years	7 Years	
Margo	3 Years	5.5 Years	
Keesha	15 Months, 5.5 Years	6.5 Years	16 Months
Pete & Stacey	3; 4 Years	1.4 Years	6 Months
Erica	2; 17; & 27 Months; 4.5 & 6.5 Years	11 Years	
Ursula	20 Months; 3 Years	7 Years	1 Year
Pamela	20 Months; 4.5 Years	4 Years	6 Months
Amy	4 Years	2 Years	1 Year
John & Melinda	4.5 Years	2 Years	9 Months
Mary	5, 6, 7.5 Years	10 Years	1.5 Years
Ron & Becky	4.5 & 7 Years	5 .3 Years	
Christine	6 & 5.5 Years	3 Years	1 Year

* Age is only estimated for the child. Wanda's child has had bone age studies and they have indicated that her bone age is 14 years plus/minus four months. It is highly likely she is much older, and therefore would have been older when Wanda adopted her.

Several of the participants talked about the process of actually bringing their child home from the orphanage. I will use the words orphanage and institution interchangeable because participants used both terms when they referred to their child (ren)'s preadoptive homes. The

following quotations come from some of the comments I heard regarding the process of bringing their child home:

> The day before we were leaving for Russia, we got an old photo of our son [they had not seen a video or pictures prior to this day]. Once we got over there, we got on the train at 6pm at night and arrived in Kirov at 1am. We went straight to the orphanage and we were only there for a few minutes, and they brought the kids out. So, we were a little tired and a little keyed up. We did not sleep too well on the train, and so we were a little discombobulated. It was strange. They told us our daughter was blonde with blue eyes and our son was dark haired with dark eyes. And without having any good pictures, I guess I had created my little blonde haired, blue eyed girl. She was very distant when I first met her and there was not a whole lot of sparkle. We assumed she was really scared but she looked like a lost soul. Her hair was ratty and she just did not have any pizzazz to her. I don't want to say I was disappointed, but she was not the little girl I had pictured. Our son also looked disheveled but he at least had a curiosity about him and allowed me to pick him up. (Linda)

> Well, my daughter and I did not bond right away. She was kind of ignoring me and was very shy initially. I am not the world's greatest at figuring out what to do in situations like that. A lot of kids wanted to play with me while my daughter was in the corner ignoring me. So, I decided I could make her jealous which I should not have done. I began to look at other kids and say, "well, how about this one?" Some of the kids got the wrong impression that maybe I was going to pick someone new so I had to go talk to one little girl and explain that I was adopting my daughter. I didn't realize I was stepping into that one. Anyway, the adoption lady told me that the key to my daughter's heart was her stomach. We went and got some candy and my daughter loved it. That was what she needed. Then, we bought some candy for her friends so she could give all of them candy. (Sheila)

Several participants explained that the process of bringing their child (ren) home was really quick:

We were in and out in three nights. They get you in and get you out. They had told us we would be there for ten days, but instead we arrived on Tuesday and left on Friday of that same week. So, we only had the kids for two nights in Russia. (Linda)

They brought them all out at once, and we were with a bunch of other parents. We were under a great amount of pressure to decide whether we accepted the child within a three day period of time….in order to skirt a major law change in Russia regarding adoptions that was about to happen. The American embassy was seeing record-breaking numbers of American parents coming to Russia to adopt. We stood in line with our children for six hours to get the international visas. And the six hours were actually extended hours beyond normal operation hours to get out these visas. We were flying out the next day. (Barbara)

Christine also felt that the process of bringing her children home was very fast and described it as, "fun, enjoyable and a stress-free time!"

I asked each participant about the conditions of the institution from which their child(ren) were adopted. By about the fifth interview, I realized that I should not have grouped Russia and Romania together in one study mainly because the conditions of the institutions in each country varied so greatly. I saw the conditions in the institutions in Romania, and I think my reactions were similar to those of the two participants who adopted from Romania. The following are quotes from my journal entries regarding the conditions of the institutions I visited in Romania as well as quotations from the participants who adopted from Romanian institutions:

I can't believe how bare the walls are in this institution. There is nothing but metal cribs lined up side by side next to the walls. We had to borrow tables and chairs so that we could even do our work. There is just nothing to stimulate these children….no wonder they are rocking back and forth in their chairs [those who aren't paralyzed]. The smell is horrendous, and I have a nauseous pit in my stomach pretty much all of the time. In fact, I have not even been able to use the bathroom for five hours because I am so scared to use the bathroom in the institution. Every once in a while, I get up enough nerve to go visit all of the toddlers lying in their cribs barely moving….I would walk by and try to make eye contact with each of them and try to get them to smile. Some of them do smile

at me, but most won't even look at me. I haven't seen a caregiver go into their rooms for hours. I guess they just lie there all day. The caregivers bring each child up one at a time to be evaluated by our team. They have to carry most of them as they can't walk and they all look incredibly terrified. I want to tell them that we won't hurt them but they would not understand me. I try to 'look comforting' but I don't really know if I did a very good job of that. (Deanna)

Erica described the conditions of the different institutions from which her five children were adopted as all being different. The kids whose living conditions in the institutions were worse fared more poorly post-adoption than the children who lived in better conditions. She described the conditions of two of her children's institutions as being affected by a prior child's situation:

When I went over to Romania the first time, there was another little boy who was going to be adopted by another couple, and he almost died because he was treated so horribly. This couple almost did not adopt this boy because their lawyer had called and told them to pick another child that the original boy was going to die. It was almost like the kids were seen as merchandise. Anyway, they had seen him in November, and he weighed 12 lbs, and when they went to adopt him in December, he only weighed 5 lbs. They absolutely ignored him….it was really bad. So, as a result of this situation, all of the kids that were bound for America were put in one room. So, my children were in that room, and because the Romanians were so worried about the backlash they might receive, they really took care of the children bound for America. So, although it was a sad situation, my children made out well and lived in a little better situation. (Erica)

The other participant that adopted her child from a Romanian orphanage described the conditions as follows:

It was traumatic; it was traumatic to even go there. I couldn't even talk about it for the first year. I can talk about it now, but there were just such incredible levels of deprivation, which is the best way I could describe it. There was just a permeating sense of oppression, hostility, and fear. Not just in the institution, but in the whole country…..it is just escalated inside the walls of the institution in the desperation of these kids. It was

very overcrowded, and there was no heat. It was supposed to be for preschool age children ages four to seven years old. I saw infants and kids as old as 12 and 13. There wasn't toilet paper. It was so bleak. (Wanda)

For the most part, participants who adopted their children from Russia seemed to describe the conditions of the institutions much more positively:

> The orphanage looked good. Everyone seemed really nice. The children's artwork was up on the wall. But our daughter is also one of the people who, when she walks in the room, everyone sees her! I think she fared well in the institution. (Cindy)

> From the outside, I was a little scared because the building was in disrepair, but I expected it to be run down and drab. But the inside was very clean, very nice….it was very well kept. The caregivers could not have been any nicer. The doctor really cared about the kids…it was obvious by the way the children ran to her. They would not do that if they did not really like her. The other doctor was the same way. She took a picture with our child, and as soon as the picture was done, she started to cry. They turn over a large number of kids at that orphanage. It must be so hard. (Jean)

Barbara reported that the conditions of her son's institution were very good but explained that the lasting memory of the experience was the smell:

> But I think that everyone that goes to an orphanage comes back with a multi-sensory experience, and the one thing that had the longest memory was the olfactory sense. I think that everyone that goes remembers the smell because it has a very powerful effect. So, that would be the only real negative part of the initial experience.

Participants had varying amounts of information about their children's' preadoptive histories. Some of the adopted children spent time with their biological families before being placed in an orphanage/institution. Others were abandoned at birth and placed in institutions. Still others spent parts of their preadoptive lives in several different orphanages. Most of the participants talked about gaps in their child [ren]'s preadoption histories. Some of the adopted children's preadoptive living arrangements are described below:

We don't know a whole lot, but both of her parents were alcoholics, and we know she was taken out of the home. She spent three and a half years in the institution after she was taken from her biological parents. (Cindy)

My son's dad died when he was two years old and his mom died when he was three years old…his mom was murdered. After his dad died, the kids lived with their mom who was very violent and was described as a drunk. My son told me that when my ex-husband and I came to pick our son up, he thought we were his biological parents and that they were alive again and coming to take him home. (Keesha)

I know our oldest son spent 3.5 years with his biological mom and although I don't know much, I know they were homeless, lived in woods, and ate from dumpsters. (Laura)

Barbara and Margo talked about how they made sense of the little preadoptive history that was made available to them:

There was vague information in his records, so more of what we had to do with the information was read between the lines, which is why it was so important to have the knowledge about what certain things meant in Russian records. Back in the time when we adopted, the idea of video tapes was just emerging, and so all we had was a black and white copy of a color photo of our son. (Barbara)

We know very little about our children's' preadoptive history and are not convinced that any or all of it is true. We know nothing about their birth fathers except for their names. We were told that our son's birth mom is Gypsy and very young (14YO). Our daughter's mom was older and mentally retarded. (Margo)

Wanda's adopted daughter from Romania remembers details about the abuse she endured in her preadoptive life. Wanda tells parts of her daughter's horrific story and the lack of information in her daughter's record regarding the abuse that she endured:

My daughter is being treated for Post Traumatic Stress Disorder as well as her attachment and learning problems, and yes, [when it is the] middle of winter and someone shoves a

burning stick up your vagina, you would have Post Traumatic Stress Disorder also. The older boys used the younger kids for sex, the caregivers get drunk and invite their friends in and it is child prostitution for a profit. I don't even know a lot of it, but the little I know is enough. There is probably a lot more because I have heard from other families and workers that in orphanages nearby, soldiers would come in and use the babies for target practice in front of the other kids. The records said that she had perfect APGAR scores, mom had a normal pregnancy, no surgeries, and vaccinations were up to date. But there was a lack of documentation about the physical trauma she suffered. She has scars all over her body from the institution. She also has burn marks. I saw her on January 8th, picked her up on January 10th, and found out the social worker was over at the institution on January 9th because my daughter was in the clinic having hot compresses applied to her genitals, which is very suspicious. There are no records of any of this.

Decisions during Adoption Process

Although I did not ask many specific questions about the families' preadoption decisions, other than about their preparation for the adoption and what their expectations were going into the process, most of the participants wanted to share how they made some of their preadoptive decisions. For example, some participants talked about their rationale for adopting in general while others discussed how they chose from which country to adopt. Others wanted to talk about how they chose their adoptive children and decided how many children they should adopt, as well as what gender they should choose. I feel that it is important to include some of their responses since most participants felt these things to be important aspects of their adoption stories.

Linda listed the following when discussing her and her husband's rationale for wanting to adopt:

Our rationale for adopting was just to bring these little kids over and have some fun and run and play games and do family things….to do the altruistic thing of being decent to the rest of the world and help these poor little kids out. (Linda)

Barbara and her husband said that they had always thought adoption was a good idea:

We never labored the thought of adopting over not adopting or preferring a child of our own. We were fully accepting of the idea of adopting. We chose Russia because it had some links to my husband's cultural heritage.

Pete and Stacey were not on the same page, at first, regarding adoption. Pete described himself as the 'dragger' and his wife as the 'one being dragged'. They went to family counseling so that they could make a collaborative decision about whether or not to adopt. Although Stacey says she would have been fine never having children, she does not feel like she was forced into the adoption and feels that she could have put her foot down and refused to go through with it. However, she does feel that their decision to adopt was much more pragmatic than it was emotional. Louis felt that a school aged child was the best fit for his situation of being a single parent and knew that there were plenty of older children that needed a home. Sheila says she adopted her child knowing that she had medical problems because, "I feel like a non-orphanage situation is always better for kids and so I did not care what her problems were, she would be better off with me and I am going to help her get whatever she needs."

Cindy and Lindsey thought it was important to share how they finally made the decision to adopt at all and then to adopt from Russia:

A friend of ours in college, whom I reconnected with after many years, had adopted a little girl from Mexico, and we really liked this little girl, and so we were having lunch one day, and I said, "I think I would like children." So, we spent a year with one of us going, "yes, let's do that" and the other one saying, "No, I really don't think it is a good idea." But once we finally made the decision, we wanted to adopt the fastest way possible. So, it took us a while to find an agency that would be okay with us because of my age and our relationship. We knew another lesbian couple that had gone through our agency and said that they were gay friendly. We thought we wanted to adopt from China, but by the time we went to our agency, they were doing most of their work with Russia. So, it was kind of funny because a lot of people wanted to go get the child that looked like them with blonde hair, etc., but we did not want an American looking child. In fact, Eastern Europe was specifically not on our list because we had heard the horror stories. So, it was almost a technicality that we adopted from Russia since it was the fastest and easiest process. (Cindy and Lindsey)

Wanda and Louis described the process of choosing the country from which she would adopt:

> I worked through an adoption agency. I went to a workshop on single parent adoption, and at the time I was looking at any country. Based on what countries were open at the time and the cost to adopt a child, I narrowed it down to Romania. (Wanda)

> At first, I was thinking about Romania because I was aware of the situation over there but at the time I was adopting, Russia was more organized with the adoption process. I considered Romania, China, Vietnam, and a number of other countries but decided Russia was the best match for me. (Louis)

Jean was quite explicit about her and her husband's process of deciding which sex child to adopt from Russia:

> The thing with intercountry adoptions, you have to specify which sex you want and, that was sort of hard because we tried to figure out what would fit best with our family. I told our oldest daughter that was living my dream because I always wanted an older brother with a younger sister. We thought since she was the middle child, one child the same sex as her would probably be better. Now, I sometimes wonder if that was a good decision! (Jean)

Similarly, Sheila discussed her decision making process regarding gender of her first adopted child:

> They sent me two faxes of photos, one of a boy in Ukraine and another of a girl in Russia. The boy looked cuter and he did not seem to have as many medical issues. After a long week of trying to decide which to adopt, I decided I could get a girl in the public restrooms easier and decided on my daughter.

Agency Helpful/Not Helpful

As with many of the other questions, there were mixed impressions about whether the agency was helpful or not helpful. Again, I think whether or not participants found the agency helpful may be tied to the year that the adoption took place, what they expected from the agency,

how developed the agency was, and which agency they chose. Ursula found the agency they worked with particularly unhelpful. She stated that, although she and her husband specifically made it a goal to not adopt a child with fetal alcohol syndrome, they ended up having two children with either fetal alcohol syndrome or fetal alcohol effects. The following statement demonstrates Ursula's perception of how the agency was partially to blame for their situation:

> They [the agency] lied to us. They knew the children had been taken away from their parents because of alcohol abuse and neglect…it was in the court case [they did not receive a copy of the transcript until after the adoption].

Other participants had similar reactions:

We went into this pretty much on our own, pretty naively, with an agency that really did not tell us a whole lot. It was really just administrative type things they told us. There was really no substance to it. I think our agency would have let us get as many kids as we wanted. They would have said, "You want twelve of them? Fine! Have them!" (Linda)

I guess the thing that was the most discouraging in the process certainly has to do with the agencies: the lack of forthcomingness with information. They need to be more willing to provide all the information so that families can make an informed decision. (Barbara)

I think I was the agency's first Romanian adoption. They were telling parents that the kids were normal. At that time the parent network was just coming out with research on post-institutionalization issues. I copied and faxed to the agency what the research said, and they said, "No, no, no. They just need love." So, they were in complete denial, either conscious or unconscious, and wanted to get the kids out. I understand that, but it is a real disservice to the families not to be upfront. (Wanda)

Many of the participants did find their agencies to be helpful:

We asked a lot of questions of our agency. They were great and very patient. (Margo)

We didn't know what we were doing or what to expect. We had a wonderful agency that really held our hand throughout the whole process. (John and Melinda)

We liked the no-nonsense, business like approach that our agency took toward us and the

adoption. They were very logical and laid out all of the steps for us. (Pete and Stacey)

Preparation for Adoption

I asked all the participants in this study how they prepared for adopting from Russia or

Romania. Participants ranged from being unprepared to, in their words, overly prepared. The

following are examples of how participants prepared:

Before we actually started our official paperwork, we attended informational sessions by

adoption agencies. We took six, one night a week courses on adoption; especially

focusing on international adoption. Also, there happened to be two conferences on I

international adoption in the Washington DC area that we attended. It was quite a unique

situation, and our timing was right as far as having the optimal amount of education

available to us before we started. (Barbara)

We studied some Russian since the children were older. We spoke to my friends [who

had already been through it] about the adoption process. We asked lots of questions. I

was on the Internet reading and finding out as much as I could about the process. We

used an international adoption specialist to view he video tapes of our children and help

us make our decision regarding the physical and mental condition of our children.

Without an unbiased opinion from an educated professional, we could not have made the

decision. (Christine)

Jean talked about the importance of preparing her other children for getting a new sibling from

Russia:

Our other two children had to be interviewed as part of the home study. They had to be

prepared, and they were told around Christmas time that she was coming soon. They

knew we had finished the work and now were just getting the final things done. We

started talking to them about it even before we specifically knew about her. (Jean)

Several other participants also shared how they included their children [already living at home] in the preparation process for adopting their new siblings. For example:

> Our 15-Year-Old child was living with us, at the time, and he was part of the entire process. He came with us to Russia to adopt our two children and we included him in all of the discussions and decisions regarding the adoptions. (Christine)

Laura reported that she was glad she and her husband did not over prepare:

> I am really glad we did not dissect things to much before adopting because that would have taken away from our experience. But we did do the important things like preparing our marriage, finances, and household. (Laura)

Other participants said that they wished they had been more prepared. For example:

> I really wish I would have been more prepared for the possible language problems that my daughters would have. (Sheila)

> We really were not prepared for what we have gone through with our son. We had no idea. We read up on attachment problems and so forth but until you actually go through it, it is hard to really understand. (Pat & Tayna)

The majority of participants who had adopted a child from Russia or Romania in the last six years received a preadoptive video tape of their child. Usually, participants would pay a health care professional to review and evaluate the video to help them to understand any warning signs. Amy described the process she went through when she asked several professionals to review the video tape she had of her daughter (Amy and her husband went to Russia in January to adopt their baby daughter):

> One person who reviewed the video tape of our daughter said that she was obviously mentally delayed. We had three doctors look at the video and the first said that there were a lot of warning signs and problems. The second one said that she did not see any red flags and it was worth it for us to go over and look at our daughter. The third one said that she looked great! So, we ruled out the first one for a number of reasons. We had

heard from other people that the first doctor tended to be negative and she had spent the least amount of time with us and the video.

Experiences Different/Similar to Expectations

The next research question attempted to understand how participants' experiences compared to their expectations when they initially started the adoption process. The answers ranged from the parents' not having any major expectations or having their experiences match their expectations to feeling that their experiences were not at all congruent with their experiences. Linda clearly stated when asked what expectations she had going into the adoption process, "Basically, nothing…not huge expectations, but probably more traditional ones." In contrast, Ursula stated that when she first saw her children she was in a state of shock because they did not look or act at all as she had imagined. She also states, "I was not expecting to feel so alienated from friends, family, and other kids, nor feeling as though I always had to watch what I said." Laura felt that her expectations are similar to any parent whether they are bearing or adopting a child: "I had the same expectation any normal parent would have….I desired to have children and I expected it to be fun, that our family would stay together, and that my marriage would stay strong. It is our human instinct to desire children and I don't think that changes just because one is adopting a child versus bearing their own child."

Ursula also speaks of her husband's expectations of wanting an "Ozzie and Harriet family" and being able to bond with the children immediately as not being matched by their experiences. She explains, "He wanted to bond with them immediately, and it did not happen that way and I was very sick [lupus] on top of that. Everything was really chaotic, and I was lucky to brush my teeth by eleven o'clock each day."

Others described raising children with special needs as being a lot more work than they expected and described how exhausting the experience has been for them:

I have been so exhausted and overwhelmed, and it made it worse that no one had ever told me that I was going to be just dog tired. That would have helped a little to expect that. All the little factors like language and cultural differences add up….and no, those are not even little factors. (Becky)

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I think that when you are adopting, you have wanted kids for so long and you think you can handle anything. I think that the natural pattern of getting pregnant of only being able to get pregnant every eleven months should apply here. I was very grateful when my other two adoptive children did not come until a few months after my first child because it gave me time to gain experience with the schools and health stuff as well as get their rooms ready. (Mary)

We felt like we could pretty much handle anything because we had grown so much through our own work. That proved to be an optimistic assessment. It is entirely different having a child, and we could not anticipate the changes it would make in our lives. And actually, she [pointing to Lindsey] wanted to adopt two children. A lot of people keep going back for more and more. I don't know how they do it. How do they even do it financially? (Cindy)

Barbara states that her experiences matched her expectations and attributes this to how well prepared she was when she began the process:

It was a process and I was fully aware of the risks and so I did not have unrealistic expectations about the possible difficulties and self-advocacy issues in terms of the process.

Margo stated that there were no experiences that did not match their expectations. She said:

We did not expect anyone in our agency could guarantee anything. Our kids had a very smooth transition, including our trip home, during which both kids slept. And although they both have health and emotional issues, we expected them to have problems.

I specifically asked participants about any surprises they had throughout the adoption process. All but two participants named several events that had surprised them. Some similar experiences included parents finding out significant information after arriving in the country from which they were adopting. Some participants also were pleasantly surprised to have had such a good experience, given all of the horror stories they had heard preadoption.

Two of the participants reported that they did not have any surprises. For example, Barbara explained why she felt that she and her husband did not have surprises:

Before we went and jumped in to adopting, I spent about two years hanging around the process, which I think fully educated me and prepared me for everything….there were no surprises, in other words, when we went through the adoption process. From the time we got a very big medical profile on our son to where we are now with him, I don't think anything has blindsided us. (Barbara)

Christine said that she and her husband did not really have any surprises either because their friends had adopted through the same agency that they [Christine and her husband] used so they felt that they knew what was going to happen ahead of time.

The rest of the participants reported that there were at least a few surprises. Amy said that parents should expect surprises and that almost every adoptive family she knows has had really wild surprises. She says, "There is just a certain level of information that parents just can't know going into it. It is not necessarily that the agency is lying, they just can't have the information!" The following are some examples of surprises participants had throughout the adoption process:

It was a surprise that it would be so hard and we would all get sick right away. And we both lost our jobs after we adopted our children. When we got home from Russia, four of us were in the hospital. My husband and I got stomach poisoning where I really almost died and spent five days in the hospital. Our oldest was having surgery on his legs [he was bow legged]; our middle child was having his appendix out. Our daughter was one years old at the time. (Laura)

The biggest surprise was finding out the adoption worker in Maine whom I had been talking to for months, lied to me about our son being prepared for his new home. She described how she had prepared our son in detail but I later found out that she knew the child would have no knowledge of his pending adoption until we arrived in the city. Due to her lies, we did not try to prepare our son through the interpreter when we were in Russia and did not find out until 1.5 years later that he thought his birth parents were

coming back from the dead to get him. This caused a great deal of unnecessary trauma to an already traumatized child. (Keesha).

Our third surprise was that no one told us about the severe disability with our daughter's thumbs, even after we asked about the plasticity of her hands which one of our referral-reviewing doctors had noted as a potential problem. We discovered that her thumbs were pretty atrophied when we met her. (Margo)

Keesha further states that her second biggest surprise was the extent of the attachment disorder in her son. She also said:

It was surprising to find the lack of support from the adoption agencies once the child's issues were found.

Advice to Preadoptive Families

All of the participants provided a wealth of information, and each had advice for preadoptive and post-adoptive families. A number of participants suggested that adoptive parents do their own "growth work" and talked about the importance of accepting the children as they are instead of trying to make them into the child that they always dreamed of having:

My advice is for families and children to do their own work before adopting a child….it challenged everything you know about yourself and your relationship. We have had to grow in whole new ways since adopting our daughter, and it brings up a whole new layer of stuff. The fact that we are older has helped us handle things more maturely and have more patience and wisdom to hold a space for her even if it meant we had to give up doing cartwheels. I think people should also be aware of the kind of help that is out there….and research it and know that you might have to fight for things differently than if you had a "normal" child. Go into therapy, do your own work and be ready to let go some of the things in your life that you thought were fixed in stone. Accept what kind of child you have. I mean our daughter is hard to be around for long periods of time….but that is just her. (Cindy & Lindsey)

Even if a kids comes from your womb, there is still a good chance the child might have problems. They are your kid and you deal with their problems whether they are your birth children or adopted children. You just deal with it. There is no guarantee….don't go into adoption or even parenthood thinking that you will have the perfect kid. Go in knowing that, whatever comes up, it is something you will deal with. (Sheila)

Other participants talked about achieving a balance between being well informed and also following one's heart when making adoption decisions:

Once you have make the important decisions, follow your heart, and if you look at a referral, and it does not feel right in your heart, don't feel guilty because it may be that child is right for someone else. (Jean)

Follow your gut; that never failed me. (Laura)

Still other participants focused their advice to preadoptive parents on flexibility and taking a realistic, informed approach:

Be realistic when you look at the medical records….and get as much information as you can. I think you have to be realistic, flexible, and positive. (Jean)

I would tell people to spend a lot of time talking to other adoptive families first. Get a good sense of the pros and cons of adopting. Before, we adopted, we talked to fifty families before making our decision. There are a lot of things that I feel people should do to prepare before adopting. They should spend a little time getting to know the country they are adopting a child from….getting to know the culture and history because those are other things that they will need to be able to make their child feel comfortable with later on. Spend time interviewing agencies, and get a sense for how much time they are willing to spend with prospective clients. We had to know the questions to ask to get the answers we were looking for. (Barbara)

I would say to accustom themselves [adoptive parents] to the birth defects and the challenges involved. I have been lucky to spend a lot of time with other Special Ed

parents, many who are not adoptive parents, and see how many challenges they have as parents as well. I don't want them to feel like these challenges are a special punishment because they are adoptive parents. The reality is that is can happen to all parents. It comes down to how resilient adoptive parents are and how well they cope. (Mary)

Louis thinks that adoptive families should take more advantage of the great resources out there. He says:

I mean you can get a bad social worker by for the most part they are really helpful. I think that they are a good sounding board for anybody who is thinking about adoption. It gives people a chance to process things before they might happen. I also think the Internet is a great resource and has a lot of great information. I also usually recommend Dr. Federici's book, *Help for the Hopeless Child* because there are many people who do not understand the potential risk for major problems and his book puts it out there. It gives them an idea of what they might be getting into.

Overall Perspective of Adoption Experience

Throughout the majority of the interviews, participants talked about what I have named an overall perspective of the adoption experience (pre and post). Overall, participants' seemed to have a positive assessment of their experiences. The following responses indicate how participants have made meaning out of their experiences:

My philosophy is that we could have either given her 100% or thrown this child's life into the garbage can and leave her with no hope. And the jury is still out, but I think the odds are with her now. Three years ago, I would not have been able to say that. We get to see a child who smiles and laughs, and I guess that makes everything we went through worth it. (Linda)

God gives you what He gives you. I truly believe this….we were ready to adopt a year earlier and had all the medical stuff and paperwork ready, and I fell skiing and needed knee surgery. I truly believe that everything happens for a reason because our daughter would not have been available back then. …and we would not have got her, and I know she is meant for us. There may be bumps along the way, and things may fall through, and

it is terribly painful as well as a loss…..and that is where my "glass half full" perspective comes in and focusing on the positive. (Jean)

Adopting my children was part of my duty and it has more than given back to me. I feel like it is a gift to watch someone grow up. (Mary)

Family Metamorphosis

Family Roles

During the interview, participants were asked how their roles have changed within the family throughout the adoption process. Barbara went from working full-time to part-time in order to help provide her son with all of the services that he needed. Yet, she felt that she and her husband shared the role of parenting equally: "I think that in various ways, we both try to meet our son's basic needs." Likewise, John and Melinda stated: We split the domestic chores and child raising right down the middle. Melinda is at home more of the time but we try to take equal responsibility." Laura also talked about the congruence between her and her husband's ideas about parenting: "All things considered, when the crap hits the fan, we [she and her husband] agree on the most important things to us. We have established certain roles for each of us and if we crossed over those roles, our marriage would be destroyed."

Of the participants in a co-parenting relationship, most described either their partner or themselves as the primary caretaker of the children. However, those who identified one partner as the 'primary caretaker' in their household frequently said that the other parent was still a very involved parent. For example, Christine and Mary said the following:

I would say that I am the primary caretaker now but my husband is as active and involved with our adopted children as he was with his three children from his previous marriage. He is very involved. We are both disciplinarians but I talk to my children during stressful times more than my husband does.   (Christine)

I am pretty much the final authority but we are both involved as parents. My partner is a little more rigid than I am. (Mary)

Quite a few participants explained the roles that their kids play in their family in the following statements:

Usually, if people are healthy, then I think we can help each other a lot and support one another and my kids…especially one of them tries to anticipate things that would make my life easier…take care of things that are very hard. It is pretty neat because they have done this since they were about six or seven years old. My kids are very much appreciative of where they were and where they are now, and the younger child, who has no language difficulties, has no problem articulating what he/she may need. (Louis)

They [children] are responsible for their own rooms and the housecleaning. I think I gave up housecleaning when I decided to adopt three children and work full-time. We used to have a maid but now we don't, so we expect them to pitch in. When they are out of school in the summer, they all work. But before they were old enough to work, they had to do chores to earn an allowance. (Mary)

Erica, a single mom of five adopted children from Romania, had to enlist the help of a nanny (sometimes part-time and sometimes full-time), a Romanian translator, and cleaning services. She reports that she could not have handled everything without their help. While raising five children, Erica has maintained a full-time job that allows her to work from home when she needs to.

Other participants described taking on the role as teacher for their children in addition to their normal parenting duties. Some parents even began home schooling their children because they felt that the schools could not or would not adequately meet their children's learning needs. Wanda and Laura described this role:

Meanwhile, I was teaching her. I spent so much time with her at night helping her read and doing learning games. So, basically she was getting home schooled and still going to public school but then I got exhausted and thought I would end up in the hospital. I can't be her teacher and her mom. (Wanda)

Our family life was suffering because we had to resolve all of the issues that did not get resolved for them at school, plus homework, etc. The schools just could not adequately meet our sons' needs and so I am home schooling them now. (Laura)

Interestingly, all of the families that I interviewed had pets, and quite a few of the participants had adopted pets that were in need of rescue. Several of the participants described the role of pets in their family's life:

We have four dogs and two cats. They are all rescue animals. I laugh and tell everyone that everyone in our house is rescued. Our daughter is really into rescuing animals. She wants all of the animals to have a home. (Lindsey)

We have a cat. When we were in Romania staying with a host family for several weeks, my daughter was terrified of dogs. She was really drawn to cats and kittens. When we got back here she kept talking about them and how she wanted brothers or sisters. So, we got her a cat. She has a real love/hate relationship with the cat. Sometimes she is very affectionate with it, and other times she takes out her rage and aggression on it. I really have to watch it. (Wanda)

Erica reported that one of her daughters had recently sunk into a psychotic depression because her dog ran away. The dog served as a friend and support to her daughter as her daughter struggles with peer relationships.

Mary described how their family pets have played a huge role in their family life:

We have a dog and a cat and we let the kids pick out the cat….they even had a video of the cat. We have done many things to simulate adoption with animals. We let the cat have kittens so they could watch kittens being born since they were never going to watch me having a baby or have younger siblings. They were able to look for good homes for the kittens. They would interview the potential owners and visit their homes first, much like a home study. The families who adopted the kittens have been very good with our children. They send us pictures of the kittens at Christmas and so forth. So, our kids feel really good about it.

Emotional Strain

Participants talked about two main areas of emotional strain throughout their experiences with adoption and post-adoption: emotional strain on their primary relationships and individual emotional strain. Some of the participants described the strain they felt on their primary relationships:

> We have been separated for a year. The stress of raising a special needs child definitely was a factor in our separation but I would not say it is the only factor. The added stress made things very tense and diverted our attention from our problems in our marriage, so we never worked them out. (Pat and Tayna)

> My husband is still in denial about the kids' special needs. One time, after we separated, he said that he understood their special needs, but that did not last long. It has been a constant struggle with him to get him to understand their problems and we have never been on the same page about it. (Ursula)

Keesha and her ex-husband husband have been officially divorced for almost three years. Her ex-husband left her and the kids two and a half months after the adoptions took place. She does not think that she and her husband's divorce is a result of their adoptions but said:

> About two and a half months following the adoptions, my husband announced that he wanted a divorce. I did not understand why because he had wanted to adopt even more than I had. But I later found that he had been molesting our biological son for years before we adopted our other two children. Following the adoptions, he began severely molesting our adopted son. (Keesha)

Other individual participants described the emotional stress that they felt:

> I was exhausted. I was sick a lot of the time especially when they started going to school and brought home all those germs. They did not get sick, I did. And it was, frankly, overwhelming. I believe I was depressed because of my personality. I thought there was something wrong with me because I was having such a rough time. It is really difficult. Whenever I talk to people, whether it is those who have adopted, are getting ready to

adopt or have birthed their own children, I say that it is no comparison to   being older when you are raising children. (Becky)

It was rough, I mean we went through 18 months like this even though our first month or two were not that bad, but at the 18 month point, I would have to say, I was close to a breakdown. Normally, I am one of those people, that when the going gets tough, I get going, but she was wearing me down big time. She was the last thing I thought about when I went to sleep and when I opened my eyes in the morning, I had to think about how I was going to get through the day and how can I help her out? (Linda)

I was very depressed after we adopted our two children from Russia and I lost over 40 pounds within three years. I sought mental health counseling to help me cope with my depression. (Pamela)

Stacey reported that it has been a more difficult adjustment for her than it has been for Pete [her husband]:

I think there is an emotional adjustment period for adoptive parents, no matter who you have talked to or how you have prepared. It is like one day you are not a parent and the next you day you are. I don't think there is anyway one can prepare for the trauma of the instantaneous transition. Birth parents have   some of the emotional adjustment and transition time when they are carrying their child in their womb. Whereas, I was instantly the parent of two toddlers! I have had a more difficult transition time than my husband has. But I think it is pretty common for adoptive moms to go through a period of emotional adjustment and I think there should be more room to talk about it versus having people look down on you for going through it.

Adaptation of Family

All of the participants and their families adapted to their new family situation. Some adapted easily, but for others, it was more difficult:

We have stumbled a little bit, just like everyone does but we learn day-by-day. She is a wonderful child….the kind of child that every parent dreams of having. (John and Melinda)

One of the favorite quotes among some of my friends and I is: "We are trying to help dysfunctional kids live in a functional family." That is how we, as families, adapt. (Erica)

I think my daughter is attached to me, which is very good news. It has been hell, and for that first year I really did not think I would make it, and I considered relinquishing the adoption on more than one occasion. But my daughter is so courageous, and she has moved through it. I think she is secure enough in her attachment now that some of her really deep trauma and pain is now surfacing and is causing more serious problems. The first six months she was so terrified and she would come into my room at night and lay on the floor in a sleeping bag and have her arm up and I would have my arm over the edge of the bed…she hung on all night long. When I went to the bathroom she would stand at the door and ask if I was still in there. If I went out to get the mail, she would beg me not to leave her. She doesn't do these things as much anymore so I know she is less scared. In fact, the Easter Bunny and Saint Nick could not come into the house for two years. Everything was delivered on the steps because if they could get in so could others who had abused her. (Wanda)

Linda described a different level of family adaptation that occurred after she and her husband had a better understanding of the challenges facing their daughter and had located a good team of professionals to work with her:

After everything we had been through with her [daughter] and looking at how much she had improved……we have decided that her burden is a little larger than most kids, and so we need to cut her some slack. If she is on the same level academically as other kids, then I tell people to leave her alone about school. I am more concerned about her mental health; that is more important to me. She is a bright kid, and when she decides she wants to get into academia, and then she will. We have a good time together now….she and I go

to lunch and fix each others' hair and she paints my nails. We could not have had those

interactions before.

Several participants talked about changing from full-time work to part-time work in order to

accommodate their children's' special needs:

I worked full-time until last year, but went on a part-time schedule primarily to

accommodate our son's special needs. (Barbara)

I am here [work] on a part-time schedule. My daughter has a million activities so between

the activities and taking her to her appointments for services, I can't really manage

working full-time. (Wanda)

Christine discussed the adaptation of her marriage to their new family situation:

I think that my husband and I have grown together because of our adoption. I have 3 step-

children who   did live with us since their early teenage years and honestly, there was

some feeling of resentment on my part for several reasons: I was raising someone else's

kids; that I could not have my own kids; and that their mother could not raise them. We

would argue about my disciplining them (my husband liked the good cop, bad cop

routine and he didn't want me to have too much say in their discipline). I just wanted

"our" children badly. With the adoption, that happened. We were able to parent

together, so that eased our relationship. I felt like we had a common goal for these

two children.

Parenting Techniques

Participants described their techniques for helping their children adapt to their new family

life. A major theme across most of the participants' parenting techniques was that providing

structure, i.e. setting rules, providing consequences for not following these rules, and keeping

things consistent across people and time, was a necessary component of raising them properly.

The following quotations allude to the value of providing structure for their children:

Let's just say that there were times that my husband and I were not on the same page, and

we had to change that. That sent a clear message to our son that we were consistent about

what we expected at all times. We could not be playing good cop, bad cop with each other. I think that in many ways we have been unfailingly consistent with our son in terms of everything and understanding the need for established routines and expectations. I think that has been big. (Barbara)

My house is very boring; it is a structured place where you know we do the same thing each morning and each afternoon, but I know this type of routine is good for them. They do not process the way that normal kids do, and their verbal skills are not fine, so we spend a lot of time playing red light, green light. One of my sons is the only one I really have to do this with a lot….when he is on code red; he has to stand right next to me. When he is on code yellow, he has to be in the same room as me or the   next room over and within eyesight of me. If he cannot do this, then he is back on code red. When my kids first came, I built them a play ground and they had to stay within the play ground area for about a year. Then, I started letting them in the front of the house also, and then eventually they were allowed to go between our house and four houses down. (Erica)

My husband and I switch off being good cop and bad cop. We have fit it into a nice pattern. We knew that there were some things that we would not back down on and the fact that we have been consistent, will make or break our boys. A good portion of our family life is spent trying to help our children trust and be part of a family. We have these things called, "family choices" and we ask our kids to make them….they are basically a set of rules that we ask our kids to follow. We have never known a time when our boys have actually made a family choice! When we are not there, they will ALWAYS make the wrong choice. Therefore, they are always restricted (Laura)

Erica even hired a Romanian translator for the first months after bringing her children to the United States so that she could ensure that they understood the rules without pressuring them to learn English: "This lady was here to do nothing but translate for them so that they would understand the rules. This way, there was no doubt about what the rules were and how they had to understand them."

Several participants also described other techniques for dealing with difficult behaviors. Linda, for example, explained how she reacted when her daughter was acting out of control:

Sadly, we had to do things we also have done with our pets. Sometimes I would look at her and just say, "You look like you're in a mood today where you want to pick a fight…..well, I am not in the mood and you are not going to spoil my day." I would throw her for a loop by turning on the music and dancing around the kitchen, and she would figure it out pretty quickly and say, "I am too going to ruin your day." And I would say, "No, you won't [in an indifferent voice]." Sadly, the reverse psychology worked. We also do a lot of, "it is your choice," behavior modification type parenting.

Participants also talked about the importance of assessing their children's levels of development (emotionally, physically, and academically) and making decisions based on those assessments. Jean, for example, explained her decision to keep her daughter out of kindergarten for another year:

I am choosing to follow my gut, which tells me to keep my daughter out of kindergarten next year. She is doing precursors for kindergarten but I just worry about her not being emotionally ready especially since I still need to rock her. Plus, kindergarten is all day…..9-4pm, and I don't think she can handle that. (Jean)

Other participants described attempts they made as parents to comfort their children:

Just all of a sudden, she would start screaming and sadly, since we could not really talk to each other, I kept thinking something must be hurting her or pinching her. I could never find anything. We would try to comfort her and pick her up and do those things, but we found out that once she started screaming and crying, there was nothing we could do. (Linda)

One of the benefits of adopting an older child was that she was a sponge for language but because of this, she was able to start telling me very early on about the abuse. She asked me in the first months she was here where my stick was because she was used to be whacked before bed. Sometimes, I just get so sad because of everything she has been through. We cry together. (Wanda)

Finally, most of the participants talked about ways in which they tried to foster attachment between themselves and their children. Amy described her efforts to help her son attach to her:

> It was apparent to my husband and I when we brought our son home that we knew what it meant to have an unattached child. Basically, we would ask him to do something and maybe he would and maybe he wouldn't, depending one what he felt like at the time….because he did not really care about us. I mean who were we? We were just strangers that walked into his life and took him home with us. About two weeks after we got home, it became obvious to me that he was not attached and therefore, I did not have control over the situation. I had done a lot of reading on attachment disorder. So, I proceeded to devote the next five months of my life to getting him attached…..we basically spent 24 hours per day and did everything I had read about or could think of including throwing cotton balls across the table to each other because it was something we could do together and laugh at together. I think he is fully attached now but I don't know how parents do it that bring their child home and put them in day care and start working immediately. I felt that spending so much time with him, 24 hours a day is what made the difference.

Sibling Relationships

Jean felt that her son showed an astute understanding of his younger sister's life in the orphanage when he gave this rationale for why she did not cry after she fell and hit her head:

> You know mom, I bet she learned not to cry because no one would really pay attention to her anyway in the orphanage…..she probably did not get much sympathy and so that is probably why she does not cry. (Jean's son)

In Sheila's family, the oldest child was adopted four years before the youngest child. She described the older child's reaction to the second adoption:

> At first my daughter was very motherly and caring. She does this when she is sure she can help the other person. It was a big shock to her when she realized I adopted a child that did not have as many special needs as she did. She was very disappointed that her new sister could run faster than her. Also, she and her friend who was also adopted

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from Russia were both looking forward to the adoption. It became more a competition to see who could be more of an older sister to my newly adopted daughter. My first daughter's friend is more outgoing and so she was winning that battle. My oldest daughter withdrew at this point and was unhappy about the situation. Now, they get along okay but each is happy to point out the faults of the other one. I always know what each are up to! (Sheila)

In Laura's family, all three children were adopted from Russia and she told me about the unique relationships her sons have with their younger sister:

The boys know that our family is better off because we have our daughter as a member. They would defend her tooth and nail. She is a 'strength to be relied on' and they know it so they have never shown any jealousy toward her.

A few of the participants have blended families and they discussed the relationship between stepchildren and the adopted children. Christine described the sibling relationships in her household as follows:

Now, we have a blended family and the siblings (my three older stepchildren and our younger two adopted children) get along great. The two younger ones look up to the older three and cherish their time together.

Margo describes the sibling relationships between her stepchildren and adopted children as follows:

My stepdaughter, who was 11YO when we adopted our children, has always played with the little ones and continues to do so. Our stepson was and continues to be cordial but is not very excited about them. He really doesn't consider anyone who is not a blood relation to him as family.

Finally, Keesha described how much her eldest son had helped her throughout her family's adaptation:

My biological son has been incredibly insightful and caring. Even though he was only nine years old when his siblings were adopted and his dad left, he took on a lot of responsibility, and our family could not have survived and flourished without him. He loves his brother and sister and even talks about coming home after he is in college to protect his younger sister from 'boys'!

Family Resilience

Quite a few of the participants talked about their partnership as a strength in their family and as something that helped their family adapt to the new familial situation post-adoption:

Fortunately, my husband saw what I was going through with our daughter, although not as intensely. He knew we were going through a tough time, and we had to try and do whatever we could to try and get this kid together. My husband knew that I was going to have to fix the situation and do whatever and spend whatever to do so. We both wanted to get her squared away and stayed together on that, whereas a lot of couples argue about it. We felt like there was really no choice. We needed to stay together on this, and we did (Linda)

Our [she and her husband] philosophy is different now than it used to be when we first adopted. We always have a sort of emotional reserve available…..a little extra bit left over because if we strain ourselves totally, we will have nothing left for the next thing that happens….we never give our last emotional piece away. This helps us as a couple and as parents. (Laura)

My husband and I have a good marriage. We have always been good communicators and we truly love each other. I think that this has helped us tremendously. I think we have so many special needs in the home [their biological child and child that was adopted domestically also have special needs] that we are very accepting of each other and our children. (Pamela)

Other participants focused on their faith as being the key to their resilience. For example:

One thing that has helped us cope is our faith in God's provision for our family despite hardships and challenges. It is impossible for me to believe that my son was brought to our family only to live without emotional connection to other people. I cannot believe that there is no way for him to heal. These beliefs have kept me going. Although we have much less income than we did before the adoption, we have been very lucky financially to have had substantial assets to call upon. This has allowed me to concentrate on my children's' well-being without having to panic over finances. (Keesha)

Participants talked about the strengths of their family unit as having helped them be more resilient:

The fact that we were educated helped us a lot. We did a lot of research prior to carrying out the adoption. We had also raised other children so we were experienced. Both our parenting experience and education served as assets for us. (Christine)

When times become particularly stressful, I think we usually pull together as a family and give the person struggling, and each other, ultimate flexibility and support. (Mary)

Resilience……we are resilient. I keep telling my daughter, "You think you are strong, I am stronger!" It takes a lot for a kid to walk out of the world they know and get in a car with a stranger and move to a different country. She continues to be cheerful, optimistic, and have a good sense of humor. Communication has been a real strength of ours. The big thing is, we are stuck together, and we are going to work together, and nobody is bailing out. She knows she has an ally no matter what. (Wanda)

Similarly, when I asked Laura about her families' strengths, she spoke mainly about her daughter:

She is autistic, eight years old, brilliant in some ways and mentally retarded in others. She is our family's delight. She really binds us [family] together. For a little girl who is in complete agony, she does not complain at all and she wants to do is live life. She is such a delight and she infects the whole family with it. She is elevated above so many other human beings.

Connection to Child's Country of Origin

There was a theme across the participant's stories about how to integrate culture into their children's' lives and how to keep them connected, in some way, to their country of origin. There were also varying methods of doing it. For example, Jean talked about an ongoing relationship that she maintains for her daughter with another little girl from the same institution so that her daughter would have someone in her life with which she can share her story:

> She was adopted from Kirov, Russia and we talked to several families and have a nice network in thisarea, actually, who have also adopted from Kirov. For whatever reason, our agency has done a lot of adoptions out of this particular orphanage that our daughter lived in. I think one of the reasons is that these children are going to grow up knowing each other. And, for instance, one of her best friends lives the next street over, and they are five days different in age but she was adopted 14 months earlier. So, they were crib mates, and now they play together. We try to keep that relationship going.

Others described their confusion about how to integrate culture into their child's life. For example:

> There are cultural issues. When the child comes from a past like that, that is loaded like it is how do you create a sense of pride about their culture and who they are? (Wanda)

Some participants talked about their hesitancy to share too much of a child's history with them:

> Before, I got too far down the line, other adoptive parents suggested that I never tell my kids about their preadoptive situation because they will identify with it and feel bad themselves. I just ask them what they know. I told my one daughter that her parents were a young couple and could not handle her special needs so they placed her in an orphanage where she would have a better chance of growing up. I tell her this is how they do things in Russia but her parents did not abandon her. (Sheila)

Child Characteristics

Positive Attributes

Throughout the interviews, participants freely talked about the positive attributes of their children:

> Our daughter is a very well adjusted child. I think she was ready to be adopted and we have had very few problems. (John and Melinda)

> Our daughter is very affectionate. We were surprised because we were expecting it not to be so easy to bond with her. (Jean)

> She is smart; there is no doubt about that! With most kids, all of these parenting techniques I tried would have fooled them. You could only do things twice with her, and she would know what you were going to do the next time and change her plan. She learned how to survive. Our daughter decided that if she did not communicate with anyone and just went about her business, people would leave her alone. So, she learned how to isolate herself. Even the first therapist was very impressed with her ability to do amazing drawings. Everyone kind of felt that maintaining that skill was unusual given what had been through…her fine motor skills were just amazing. She is also physically very talented….a good swimmer and good at gymnastics. (Linda)

The majority of participants talked about their children's talents despite their intellectual, psychological, and physical limitations:

> Thankfully my daughter has talents in non-academic areas! She is really athletic. She is in soccer, basketball, and dance. She swims. She is musical and plays the clarinet. She is very talented. (Wanda)

> She played soccer at five years old and she did gymnastics. She did well. I have always been amazed at how well she does in sports despite her arthroglyposis. (Sheila)

Wanda describes her daughter as appreciative and described the following event that showed her [Wanda] that her daughter was appreciative:

When she was in second grade, someone at school told her Saint Nick was really like an angel and so if she wanted to give a message to God, Saint Nick could give it to God. For a while she was obsessed with God giving her a dad. She would try to hook me up with all of these strange guys like the cable guy or the guy at the gas station. She would coach me and say, "Now, take a deep breath, smile, and go   talk to that guy." So she wrote this letter to Saint Nick and I thought she was going to ask for a dad but instead she taped a piece of gum to the letter to Saint Nick and said, "Here is a piece of gum. Please give this to God for me." Love, _____. P.S. Tell God thanks so much for letting my Mom get me out of that orphanage."

Negative Behaviors

Most of the participants also described, in detail, some of their children's' negative behaviors that they felt signified some of their problems. The following are some examples:

Our daughter was jealous of our son [both children were adopted from Russia]. Not jealous of his behaviors but jealous that we had fun with him. We weren't allowed to have fun. She was even going after our son. Like she would go to the top of the sliding board, and he would follow her sweetly, and when he would get to the top of ladder, she would kick him square in the chest and send him to the ground. She would bang his head into the bathtub and one time they were actually being quiet and because I think I needed that couple minutes of quiet, it took me a while to notice. When I did, I went running back to my son's room, and she had little things of plastic and was heating them up on the light bulb and putting them on his skin. Did she really know she was burning him? The bottom line was he was at risk. (Linda)

My daughter is very prone to accidents happening on significant days, holidays; birthdays….she'll break a foot or sprain a knee. On Mother's Day she threw a rock at a car and broke a window. Her therapist asked her what she thought her body was trying to tell her with always having accidents on special days. My daughter said she was mad and angry and doesn't want to have to grow up because she has not been able to be a kid long enough. (Wanda)

Let me tell you about the rages we have had the past few days. He pulled a knife out on me Friday night I swear you can see his face change when he rages. Anyway, he grabbed a big carving knife within a second and said he was going to kill me. I just sat down and calmly said, "you are the only one fighting here. You say I am going to hurt you but you are the one standing there yelling at me and threatening me with a knife. I am going to sit on the couch and when you are ready to talk, we can talk." He said, "Well, if you do that then I am going to kill you." So, I said, "Alright, let's see what happens." I really did not know if he was going to launch at me. He finally put the knife down and said he did not want to kill his mom. I said, "That is a good choice. You will be much happier making that choice." After he rages, he has great remorse and begs me not to tell anyone. (Ursula)

Child's Personality

I asked the participants to tell me about each of their children. Most of the time, I would receive answers about their children's' personalities. These are some examples:

We have a friend, who has a little girl, and she was over here one day, and she wanted to go home early, so I was holding her until her mom came. I remarked to her mom how nice it was to have a child just to hold. The mother said that our daughter was not a cuddly child. She is right. Our daughter is very hard…..we have been trying to teach her how to hug and relax. And on the other hand, I was not prepared to deal with how readily friendly she is with everyone. We would be in a grocery store and she would say, "I have two moms." We have tried to teach her how to be with strangers but it is difficult because she is so outgoing. Our daughter is an extrovert, and we are both introverts. (Cindy)

Our daughter is so much of a people person. She has a choice between being with me or with other kids…she will definitely choose the other kids. From the minute we set foot in Switzerland, she wanted to be with other kids, and she was very headstrong about it. And that was on her information sheet when we went to adopt her…that she was strong willed. Although it is a little hard to deal with sometimes, I think if she keeps this personality, she will go far. She is also extremely regimented about rules. Her shoes have to be side by side at all times and if our son's shoes are not side by side, she will go fix

them. She is also our food police and tells my husband when he is talking with his mouth full. (Jean)

And by nature, both of our children are pretty stubborn. They are not very compliant and I have no way of knowing whether this is just their personality that they were born with or if it has become their personality as a result of living in an institution. (Stacey)

Also, Laura describes her perspective on her sons' differing personalities:

Our son has some attachment issues. He carries a lot of emotional baggage with him at all times. He wants to go back to Russia and feed the other children and his biological mom. He does not understand why he was adopted over other children. Whereas, my younger son has standards he holds for himself and standards he holds for everyone else…the standards for everyone else are much higher.

Child's Appearance

Throughout the interviews, most of the participants commented at one time or another about the appearances of their children. Some of the time, these comments were made because they were describing the child's medical problems, while at other times, participants described their children's appearance to give some context for the way others treated them. Several of the participants said that their children looked like them. Quotations from participants that described their children's appearance as an aspect of some of their problems include:

Our boys are both beautiful but our younger son is beautiful and sensitive and so some of his peers have called him "gay"….he has been beat up on the playground. 4, 5, 6 boys were beating him up at one time. (Laura)

Our daughter was born without a left ear which is one of the reasons why we think she was not adopted at an earlier age. They were getting ready to transfer her to a home for the deaf. The child is not deaf but because it is a malformation, people were not adopting her. People don't realize it is purely plastic surgery deal……people just want the perfect child. (Melinda)

Finally, the following quotes are from participants who said that their children look like them:

> Yes, we decided that if we could not have an exotic looking child [they had initially wanted to adopt from China], then we at least wanted a child that looked like us. However, from the polaroid, she looked as if she came directly out of a J Crew magazine with light brown hair. She also appeared to have strabismus [eye disorder]. When we adopted her, though, she had dark hair and dark eyes and looks a lot like me. (Cindy)

> It is interesting because all of my kids look like me and like they are biologically in my family. I am of Russian heritage. (Mary)

Child's Diagnoses

All of the adopted children whose parents participated in this study had some learning/behavioral/emotional/psychiatric/medical diagnoses which can classify them in the special needs category. The following is a chart demonstrating the disorders with which the participants' children were diagnosed:

Table 3

Child's Diagnoses

Pseudonym	DX #1	DX #2	DX #3	DX #4
Cindy & Lindsey	Developmental Delay	ADHD	FAE	
Jean	ESL problems			
Linda (daughter)	Attachment Disorder	PTSD	Auditory Processing Problems	Cyclothymic Disorder
Linda (son)	Generalized Anxiety			
Barbara	Learning Disabilities			
Louis (older son)	Speech/Language Problems	Anxiety Disorder	Learning Disabilities	

Louis (younger son)	Speech/Language Problems	Learning Disabilities		
Wanda	RAD	PTSD	Speech and Language Problems	Pancreatitus; Precocious Puberty
Sheila (older daughter)	Speech and Language Problems	Arthrogryposis	Learning Disabilities-Dyslexia	
Sheila (younger daughter)	ADHD	Reading Disorder		
Pat/Tayna	RAD	Bipolar Disorder	ODD	
Laura (oldest son)	FAS	Learning Disorders	ADD	Attachment Disorder
Laura (younger son)	FAS	Learning Disorders	ADHD	OCD
Laura (daughter)	Autism	Seizure Disorder		
Margo (daughter)	Fine Motor Delay			
Margo (son)	Learning Disabilities	Attachment Disorder		
Keesha (son)	RAD	PTSD		
Keesha (daughter)	Attachment Disorder			
Pete/Stacey (daughter)	Language Delay **	Cleft & Lip Palate		
Pete/Stacey (son)	Brown's Syndrome			
Erica (youngest daughter)	FAS/FAE	Learning Disabilities	ADHD	
Erica (youngest son)	Speech and Language Delay	Learning Disabilities	PTSD	
Erica (middle son)	Learning Disabilities	Attachment Dx	PTSD	Language Delay
Erica (oldest son)	Learning Disabilities	Brain Tumor		
Erica (oldest daughter)	Depression w/ Psychosis *	Learning Disabilities	PTSD	CAPD

Ursula (oldest son)	Anxiety Disorder	RAD/PTSD	FAS	CAPD/Dyslexia
Ursula (youngest son)	RAD	FAS/Dementia**	Mood Disorder – Rapid Cycling	CAPD
Pamela (son)	FAE	ADHD	PTSD	
Pamela (daughter)	Language Problems	CAPD		
Amy	Attachment Issues ***			
John/ Melinda	Receptive Language Delays	Developmental Delays		
Mary (daughter)	Language Delays	Cognitive Processing Delays	ADHD	
Mary (older son)	ADD			
Mary (younger son)	ADHD	Speech and Language Delays		
Ron/Becky (younger son)	ADHD			
Ron/Becky (older son)	Reading Disorder	Depression		
Christine (son)	Unknown			
Christine (daughter)	Unknown			

Key:

CAPD- Central Auditory Processing Disorder   **RAD** – Reactive Attachment Disorder

ODD – Oppositional Defiant Disorder   **FAE** – Fetal Alcohol Effects

FAS – Fetal Alcohol Syndrome   **PTSD** – Post Traumatic Stress Disorder

ADHD – Attention Deficit Hyperactivity Disorder

* Felt that the diagnosis was inaccurate

** Due to a General Medical Condition

*** Feel that problem has gone away

A number of participants also described their child's physical diagnoses. These are some examples of the medical diagnoses that parents reported their children having:

She had precocious puberty. She started puberty in kindergarten. I got her in January and noticed in May that her breasts were getting bigger and she started getting pubic hair. She also has had severe pancreatitis which is really rare in kids. Her speech and language person, who tested her, really believes that my daughter has a frontal lobe brain injury from trauma that impacts her speech and language expression. (Wanda)

She has a brain defect in which her cerebellum pushes down on the brain stem and she had nocturnal seizures for a while. She has not had one in a while, thank goodness. But she is in a lot of pain because of this brain defect and when it was at its' worst, she could not sleep because of the pressure on her brain. When we adopted our oldest son, his legs were so badly destroyed from Rickets that they [doctors] had to literally break his legs and put them back together. (Laura)

One of my boys has Bilateral Cholesteroltoma which is basically ear tumors and because they were not treated in the institution, he has major hearing problems. Also, my oldest son has had a brain tumor that had to be surgically removed. Since this surgery was not done while he lived in Romania, he is blind in one eye and partially blind in the other. (Erica)

Several participants are still in the process of finding out what their children's special needs are:

We have no diagnoses other than "special needs" and "post- institutional". I believe they are still "catching up" but I will have them tested by a neuropsychologist this summer for actual diagnoses. Our son has shown signs of Tourette's syndrome. It has manifested itself in a facial tic since he's been home. It has really not affected him, but we will have him tested this summer for any delays or learning disabilities that may be associated with the syndrome. (Christine)

My younger son has symptoms for Obsessive Compulsive Disorder and Bipolar disorder but never received diagnoses for them. In my opinion, my son just has a brain chemistry

disorder, NOS (not otherwise specified)! My doctor is currently writing a report for the
school. I guess I will find out what his diagnosis is at that point! (Mary)

Some participants tried to make meaning out of their children's diagnoses/special needs:

We were told it was very common for people who live in an institution to not talk much
because why bother….no one will listen. And recently, everyone around us has been
having babies, and so we have been able to see new mothers with their newborns. We see
constant interaction between mother and child. It made us more aware of what our
daughter missed. (Cindy)

There are several theories about why she got her period so early. Some have to do with
trauma and abuse, others attribute it to stress and her adrenaline and secretions are still at
the "fight or flight" level. Another theory had to do with malnutrition. The medical
community points to three factors causing pancreatitus in children: alcohol and drug
abuse, physical trauma like getting punched in the gut, or genetic. We have no genetic
history. (Wanda)

It is so nice being adoptive parents because it was not my genes that caused their
problems. It wasn't my behavior that caused their problems. I can choose. I can blame the
birth parents or the treatment in the orphanage. (Sheila)

Linda talked about how she thinks an auditory processing difficulty affects all aspects of her
daughter's life:

We have discovered that she did have auditory processing problems, which make things
hard. I don't think it matters that she was here in this country. I think she was just having
problems with language in general, and she was probably pretty frustrated. Not to excuse
it all, but I often wonder if the auditory processing and language delay was not a lot of
the problem and her just doing anything she could to let us know that she was displeased
and not able or willing to communicate. I have started to believe that unless you live with
auditory processing difficulties, you can't understand how much it affects every waking

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minute of every day. It is a very long day for her at school. She has to spend half of her energy just trying to listen to what people are saying.

Ursula said that it is not uncommon for post-institutionalized children to have a 'vegetable soup' of disorders. She contends that professionals need to understand that the children might have a combination of disorders.

Social Response to Adoption

Services Provided

The following is a chart of the services that the parents reported having for their children, themselves, or the entire family.

Table 4

Services Utilized

Pseudonym	Phys	SPLS	ATT	BM	Play	EIS	IEP	SE	FT	NE	PP	AM	OT
Cindy & Lindsey		X	X			X					X	X	X
Jean		X											
Linda		X	X		X		X			X	X		
Barbara								X					X
Louis		X								X			
Wanda		X	X	X	X		X	X			X		
Sheila	X	X					X	X	X		X		
Pat & Tayna					X		X	X		X	X		
Laura							X	X		X	X		
Margo							X	X		X			
Keesha		X	X	X			X			X	X	X	X
Pete & Stacey	X	X								X			X
Erica		X					X	X		X	X		X
Ursula		X	X	X			X	X	X	X	X		X
Pamela		X	X	X			X	X		X	X		
Amy			X										

John & Melinda		X										
Mary		X					X	X		X			
Ron & Becky							X			X	X		
Christine								X					

Key:

Phys= Physical Therapy   **SPLS**=Speech and Language Services

ATT=Attachment Therapy   **BM**=Behavior Modification

Play=Play Therapy   **EIS**=Early Intervention Services

IEP=Individual Education Plan   **SE**=Special Ed

FT=Family Therapy   **NE**=Neuropsychological Evaluation

PP=Psychopharmacology   **AM**=Alternative Medicine

OT=Occupational Therapy

In addition to the services listed in the above chart, all of participants took their children to see pediatricians. Many of the participants also took their children to see specialists in the medical field such as: neurosurgeon, endocrinologists, neurologists, ophthalmologists, etc.

Adequacy of Services Provided

   Another research question examined the participants' experiences with mental health and healthcare professionals. An overarching theme across the data for all of the participants was that health professionals showed a lack of understanding of, support for, and validation of their adoptive children and the dilemmas they faced. Linda exemplified this theme through her statement, "I had taken our daughter to a psychologist that our friend recommended, and she seemed like a very nice lady but I don't think she believed the extent of what we were going through." Later in the interview, Linda explained the situation further, "The psychologist was great, but she wanted to do play therapy, and I thought that she [daughter] would be more than happy to sit down and play with you. But then, my daughter and I would leave her office, and my daughter would look at me as if it was funny and then would go back to her usual self." Linda felt as though the psychologist did not validate or believe her experiences with her daughter:

"The psychologist thought I was crazy and that I expected way too much out of my daughter." Linda also discussed her experience with the preschool teachers she dealt with:

> Her first preschool teacher was not good in retrospect because everyone would sit for story time, and my daughter would go play in the kitchen area. The teacher would just let her because she was not bothering anyone. The teacher basically let my daughter do what pleased her. I told that teacher that if the other kids had to sit quietly and listen to the story, so should my daughter. My daughter was not poking anyone or not crying, so they left her alone. Eventually, we had to get the teachers to lay down the law with our daughter. We told them they were not really helping her. (Linda)

Ursula experienced similar difficulties, especially with the school system. At one point, the school even violated her older son's IEP (Individual Education Plan). She expresses her feelings about working with outside services:

> Also, school was a big issue to wade through because it was really hard to get my sons the services they needed and to get teachers and therapists to understand the differences between post-institutionalized children and those who have never lived in that type of environment. In other words, it was like working through a maze when working with the school system, and I really started out naïve and had to figure things out for myself."

When I asked her what the school and other health professionals could have done differently to help her, Ursula stated, "It would have really helped to have someone validate my experiences so I would not have felt like such a nutcase." Her feelings of not having been validated by the very people that were supposed to be helping her further supports the claim that how health professionals respond to their clients' pleas for help can significantly impact families' experiences.

Keesha and Sheila also shared some of their thoughts about the school she has had to work with to get their children the help they need:

> It is disturbing to me that schools are inclined to believe that parents know nothing about what is good for their children. In my experience, the schools have refused to implement simple behavior modification techniques recommended by my son's therapist. It seems

like each person in the school has their own view of what this child needs and becomes very defensive about any suggestions for change. (Keesha)

I did not fully get that she had a language problem until I went back and reread this document that said language delay. They had told me not to worry because they were a language based curriculum. I felt betrayed when I figured out that it wasn't that they did not catch it….it was they caught and did not tell me about it. I felt betrayed because even though she was receiving all this help, she could not get past the brick wall of reading. Finally, I got the sense that they did not want to tell me that the school system could not handle it because I could have sued them for special services. I did not sue anyone. I went out and found her the services she needed. I am not the most observant or distrustful person but I assumed that the school system could handle it and if they could not, they would let me know. (Sheila)

Wanda's experiences with the school system were similar. She states:

One of my big issues is that it has been totally overlooked by the school systems to educate the schools about the special needs of post-institutionalized children. From day one, I have been fighting with the schools to give my daughter services. We are yet going through another evaluation as we speak. This is now the fourth one to get her services, and I have paid out of pocket because the school would not. I have hired tutors, I have home schooled, you name it, I have done it…. To compensate for them saying that she does not meet the criteria for special services. This year, I am close to hiring an attorney because I have friends who were in a similar situation with getting their adoptive child the services he/she needs at school and hiring an attorney was finally what got the schools to listen! I know a lot of families who have adopted from Eastern Europe, and I have not met one who is not struggling with the schools.

Laura recently began home schooling her two sons because she felt that the school was not providing them with what they needed. However, she had a unique perspective on the situation:

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There have been really big problems with the school system. I came to realize that they did the best they could with the resources they had. I fought with them for five years and I could have fought more but I would not have gotten anywhere with them…and what they could offer my boys just was not good enough.

Although the majority of participants seemed to have great difficulty getting the schools to meet their child (ren)'s needs, a few participants have had a positive experience with the schools they have dealt with:

We think our school is the best! I don't about other schools but the particular triad (Elementary, Middle, High) of schools in our neighborhood are excellent. People move into this area so that their children can go to our schools. So, we are just thrilled. (John and Melinda)

Linda talked about what it took for her psychologist to finally listen to her and believe that her daughter needed more than just love and attention:

Although my daughter had been urinating on purpose everywhere in the house, throwing tantrums, being physically aggressive with our son, it took her defecating on purpose all over the house for them to take me seriously. I called them up and said, "I know everyone thinks it is no big deal when she pees all over the place, but now she is defecating." There was silence on the other end of the phone, and they asked me to bring her in so we could talk. When I went in there, she said that in the mental health industry when a child starts doing this it is a sign of major depression and mental health issues. They wanted to hospitalize her. Realistically, when the child was peeing all over the place, she did not think there was anything wrong with my child, but now everyone believes me. I have been saying for a year that my child is nuts! (Linda)

Barbara and Keesha comment on the knowledge and level of awareness of health care providers:

I had higher expectations of the health professionals working with my son. I thought they would have a higher level of awareness of the needs of post-institutionalized children.

This was especially true of my son's pediatrician. He knew less than we expected him to know.

(Barbara)

The public health and human service sectors I have interacted with have been particularly atrocious. Many of the people believe that they have god-like answers but rarely offer anything that could be actually helpful to our family or my son. (Keesha)

Most of the participants shared some of their disappointing experiences with health care providers:

Their assumption seems to be that if a child has problems, they are caused by the families in which the child currently resides…this makes it particularly tough on adoptive families. However, it makes me wonder if these superior acting people can help the poor parents then why is it so difficult for an educated, mentally healthy individual like myself to get help from them. (Keesha)

The first pediatrician we saw would not do a parasite test and he really did not like me because I knew what I wanted….he wanted to treat my post-institutionalized children just like any other child which I believe is just plain ignorant. Later, we found out that one of our kids did have parasites all along and if he could have been treated earlier, he would not have had as many health problems. We even had a family doctor that was very friendly and would go to all the community events but we would not research anything he did not know. I have lost so much respect for doctors that don't care enough to research things. (Laura)

Several participants described methods for checking out health professionals as to whether they can provide adequate care for their children/family:

Sometimes when I am at the doctor's office and describe her symptoms and behavior they look at me as if I am making them up. They have all of these preconceived ideas and if they are not willing to be educated, then I walk right out of there. (Wanda)

I ask questions for doctors and if they cannot answer them, I walk out. I ask them about inoculation and what they know about the needs of post-institutionalized children and if they can't answer them, I am out of there. The best doctors care and research what they don't know. (Laura)

Other participants described their appreciation for some of the health care providers they had come into contact with and empathized with the difficulty of their job:

The physical therapist, who happened to be a mother of four herself, knew all sorts of things about which soccer league to get into, the best orthopedic surgeon to go to, etc. She was a big resource. My neighbor who was also a nurse was also a huge resource. (Sheila)

We have needed pediatricians, neurologists, psychologists, social workers, and urologists…all of whom have been great! (Christine)

Every time I think about what our neuropsychologist [gatekeeper of study] has done for us, I start crying. Without him and his recommendations to doctors, we would have been lost. (Laura)

Wanda compared the process of finding good health care providers to "finding a needle in a haystack." However, she did find some providers that she feels have done a good job:

It is hit or miss with me. I have had very good luck with a social worker that my daughter sees. The social worker is an adoptive parent herself and understands attachment disorder and brain development and all of that. She has been fabulous! A speech language person who works a lot with Eastern European kids has also been good.

Since most of the participants had come into contact with multiple health care providers, I asked them to answer questions about who had provided services for their family since the adoption took place, and how health professionals worked together (collaborated). Lindsey talks about all of the varied services she and her partner have received for their daughter:

Our daughter started speech therapy right away and has made significant improvements. We also got in touch with an attachment organization nearby that always just tells us our daughter is normal. My partner [Lindsey] thinks they are more helpful than I do. I listened to this tape of this world known expert on attachment based out of Minnesota. So, we got in touch with her, and she had us pose in different pictures and from that she could tell if our daughter wanted to model after us. She told us that our daughter did want to model after us and that she does not fit into one category. I wanted the answer, and I don't think there is such a thing. We also got in touch with the Evergreen attachment therapists in Colorado, and they basically told us our daughter was only going to get worse. They were very negative. Our daughter also receives occupational therapy and sees a psychiatrist regularly. Other than that, when our daughter was not doing so well, we called a neuropsychologist to get her evaluated but was really turned off by the office staff and so did not follow through. We even drove our daughter to see this guy in North Carolina who takes a pretty philosophical-educational approach and uses organic farming techniques. What we got out of that was that our daughter is pretty armored, physically and emotionally, but we really did not get much out of it. Finally, our pediatrician does this   biomedical treatment, and she is totally excited about her research, so we give our daughter a complicated regimen of supplements. So, basically we are willing to try a lot of things, even alternative medicine. However, we have decided there is just not one right answer. (Lindsey)

Cindy [Lindsey's partner] adds to Lindsey's comments:
Our pediatrician has been the go-between for everything and does a really good job collaborating   with others. That has been so helpful. I think our daughter has a very good team.

A number of participants talked about their wish that health providers had collaborated more effectively with one another:
I think it would have been much better if the health professionals had collaborated better together. I even went to a hospital when my son needed to get the surgery for his ear tumors that supposedly took a team based approach. I knew that this would be traumatic

for my son since he had already experienced such a great deal of trauma. However, they

did not even take a team based approach with mental health and medical health even

knowing that these kids were high risk. (Erica)

Keesha made an even stronger statement about this issue:

It has been a real eye opener to learn about the mental health system. It is fragmented and

difficult to understand. It is based on dollars and political boundaries: not the best interest

of the child. It still seems ludicrous to me that when a child is in a mental hospital, the

hospital professionals refuse to get any information from the child's outpatient providers.

Likewise, if a child leaves the hospital, he can no longer continue to use the services of

the professionals in the hospital.

It is also important to discuss another theme that emerged during a number of the

interviews: the need for support groups for adoptive parents. Several participants felt that some

of the existing support groups were not accepting of the severe problems they were having with

their children. In fact, Ursula, Pamela, and Wanda specifically talked about their experiences

with other international adoptive parents in chat rooms who told them to stop talking about their

problems because it might scare people away from adopting from Russia. Other participants

talked about wishing that there were support groups in their area where they could connect with

other international adoptive parents who were also raising special needs children. Sheila said, "I

think people who are in this type of problem situation {raising a special needs child} would

benefit from talking to others going through similar things so they would know that they are not

the only one in the world going through it." In addition, some participants talked about how the

support groups they attended were the most helpful service provided for them.

Family's Response

Again, when asked about the supportiveness of their families, participants provided a

range of responses. Some of the participants found their family members to be very supportive:

There were a lot of questions about whether we were sure we wanted to do it, but we

once we definitely decided to adopt, our parents were more supportive. They both adore

our daughter. My father died four months after we brought our daughter home, so that

was really hard. But before he died, he and our daughter shared a wonderful bond in a brief period of time. (Lindsey)

Well, everyone has been very positive about the adoption. Everyone was very supportive about the idea, and then once our son was on the scene, everyone continued to be supportive and shared his/her joy and love with us. I think that there has never been a negative response as far as the family's attitudes toward adoption in general or about our adoption. (Barbara)

Ron and Becky shared how their sons meshed in with their family immediately and described what happened at the airport the first time Becky's family met their sons:

They just became members of our family immediately. It was real interesting. We arrived at the airport and of course, there were a variety of people there including my mom and dad. Our son, being Mr. Personality reached up for my dad's hand even though he had never seen the man before in his life and they go walking through the airport. They meshed into the routine of our family day one.

Other families demonstrated a more neutral response or responses that shifted from unsupportive to supportive:

I think our parents were initially trying to talk us out of it because they thought we were too old But my mother's biggest response was that she thought we were being selfish since there would be such an age gap. And I think your father too, your parents, were playing the same devils' advocate [looking at Lindsey]. (Cindy)

The family response has been interesting. I am from a huge family, 10 kids. I have a brother who also adopted internationally from both India and Ethiopia. There are some in the family who are incredibly supportive and others who are narrower minded, thinking, "why do you think you need to go save the children of the world. That kid is going to make you broke. That kid will only create heartbreak for you when you are older." So, there has been mixed response from family. (Wanda)

Finally, some participants felt that their family members may have been supportive of the adoption but were unsupportive of them, as parents and have actually made their experiences more difficult:

> Our daughter was really sweet to them, and so they did not believe us when we would tell them all of the difficulties we were having with her. I would reprimand our daughter, and they would undermine me in front of our daughter. They would tell us that our daughter's problems were no big deal. Sadly, family and friends were just thinking of her as a poor little orphan child, and so they were trying to be nice. At the same time, they were making our situation worse. So, eventually we had to separate from them. (Linda)

> When I would call up my one sister in that first year with my daughter and tell her how tired I was she would say things like, "What is so bad about it? Why are you so tired? Well, what problems does she have? This was your choice to adopt." I stopped calling this sister for support. I have found this a very interesting dynamic. When the family is all-together, my sibs and even my parents feel at liberty to discipline my daughter and go off on her for her behavior more than they do with the other kids. "Stop chewing with your mouth open. Sit up straight. Stop biting your fingers." They just ride her about it! (Wanda)

Friend's Response

In general, participants felt that their friends had been at least somewhat supportive. However, there were a few participants who described some bad experiences with friends and other described how their friendships had changed since the adoption. These are some of the responses I received when I asked about the response from friends toward their adoption:

> I think the main thing, socially, is that the adoption experience has taken us a different direction with our friends….very few of our preadoptive friends have ended up staying friends of ours'. Most of our friends did not have children and did not go roller-skating or to animated movies. Our social life really changed much more than we expected. Everyone was all excited when we first adopted and said how they could not wait to baby-sit. None of those people ever showed up to baby-sit. (Lindsey)

We have one friend that stuck with us, and she has become our best friend because of it. She kind of went through the transition and understood our limitations and our lifestyle. She knew she would lose us in a certain way and still wanted to remain friends with us anyway. She has become an unofficial aunt to our daughter, and they have a special relationship. (Cindy)

Sheila said that she has received most of her support from other parents raising special needs children even more so than other international adoptive parents. Ursula told me ways in which friends had been both supportive and non-supportive. I asked her what an ideal friend would have been throughout the adoption process and she said:

A friend who was open-minded and would be willing to spend time with the kids and even come to therapy with us, if they wanted to play a role in mine and the children's' lives. The ideal friend would be a shadow to us and listen to me without making judgments. He/she would also not be afraid to openly discuss their frustrations and make their own decision about whether they wanted to be a part of our lives or not.

Society's Response in General

Most participants shared societal responses that they received regarding their adoption that they found to be troublesome. Here are some examples of these comments:

Our minister made an ignorant comment one time. After we had brought our daughter home, he said, "So, are you still happy with her?" And I said of course we were. And he said," So, you are going to keep her?" We said that we would not have come back with her if we did not want to keep her. People think adoption is temporary. Also, people say things like, "Well, do you know anything about the real mother?" The word "real" bothers me because I am her real mother! (Jean)

The stores are the worst place for negative social responses. I am fair skinned and my children are dark skinned so we get questions like, "Are these your children? Are they adopted?" I told this one store clerk who asked if they were my children that her comment was inappropriate and then I told the store manager to tell his clerks to mind their own business and just ring people up!" (Laura)

Other participants focused on how their children's schools had been insensitive to their family makeup by giving certain assignments:

At my kids' school, they asked them to do family trees and did not give an alternative assignment! My kids aren't able to do a family tree. They don't even know who their parents are! They have also been asked to bring a baby picture which of course they don't have. People, in general, just need to be more sensitive to adopted children. (Mary)

Over half of the participants in this study commented on how people view them as being noble or like Mother Theresa-Like because they adopted from Russia or Romania. They found these comments to be frustrating:

One of the things that I think is a public perception, and I don't think people mean anything harmful by it, is that we have done something noble by adopting our son and giving him this life. And I always respond by saying that we are the ones that are blessed to have him in our lives. It is not that we were out to become saviors. That our reasons for adopting were largely selfish in that we wanted to have children and this was one way we could do it. (Barbara)

And people in America seem to believe that adoptive parents are supposed to take care of kids until their real parents come along or are found. I will not allow that belief to influence my children. We are their family. Americans don't support adoptions as a type of family...they think we are doing a humanitarian thing. (Laura)

Also, some participants described peer responses from other children toward their child:
One of my daughter's teachers said that the kids in her class needed some sensitivity to my daughter's background because one of the kids said, "Why are you always talking about Romania?" My daughter said because that was where she was from and where she lived. Another child said, "So what, I lived in Australia." So, my daughter tried to tell the kids about how when she was four, she lived on the streets and ate out of a garbage can. The kids were snickering…they just could not relate. (Wanda)

Summary of Chapter

Although the participants had unique aspects of their families' adoption stories, there were also some similarities across the stories. In fact, all of the participants, whether they were newly adoptive parents or parents adopting ten years previously, had created meaning of their adoption experiences and developed an overall perspective that they felt encapsulated these experiences. There was a theme of resilience across all of the interviews, but the ways that the families demonstrated their resilience was often times, very unique and creative. There was also a theme of perseverance that created a sense of, "no matter what comes our way, we will deal with it" mentality. Despite the participants' perseverance and resilience, the ways in which they dealt with the stress of raising (a) special needs child(ren) varied. Some families were dealing with the stress of raising their children more effectively than others. Just as the participants adopted children with different histories, levels of need, and personalities, parents were also entering the adoption experience with different expectations, strengths, and needs. All of these factors influenced how families adapted and perceived the adoption experiences. Also, the developmental stages that parents were in as individuals, as a couple, and with the adoption were key factors in how they experienced the adoption process. Finally, participants' level of connection to social supports (services, family, and friends) seemed to better or worsen their adoption experiences.

CHAPTER V: CONCLUSIONS AND DISCUSSION

Overview

The purpose of this study was to understand the adoption process experiences of families who had adopted a child between the ages of three and five years old from Russia or Romania since 1992. My goal was to gain a clear picture of what adoptive families experience throughout the adoption process and afterward. I attempted to achieve this goal through interviewing 20 sets of parents.

I, as the researcher, have been through a whirlwind of my own experiences throughout the last three years that I have conducted research on the lives of families who adopted from Romanian and Russian institutions. Most, but not all, of these experiences have been pleasant. All have challenged me personally and as a researcher. I would be leaving holes in this research project if I failed to mention the profound effect that the participants' lives and my own experiences in Romania have had on my making meaning from the data. After transcribing a portion of the interviews, I began having nightmares of particular things that I saw while in Romania, and of things that participants had shared with me. No matter how many times I read over the transcripts or my field notes, every time I hear some of the children's and families' stories, my chest begins to hurt, and I become filled with emotion. Some of these emotions come from the hope and pride I have for these families because they have so many strengths and have endured and grown so much. Others come from sadness and hopelessness for the reality of some of these children and the families who love them. I never stop thinking about the great numbers of children still waiting in institutions for a family to love them. Therefore, in my attempts to be completely straightforward and honest, I want to acknowledge that my own secondary traumatic effects as well as the sense of pride I maintain for the participants in this study have informed my interpretation of the data. Many times throughout this project, I revisited my own experiences and pondered my reactions to the stories I was hearing. In the following pages, I will not only be comparing the results of this study to the existing literature but also my own observations, journal entries, and field notes.

Discussion

Four major themes emerged from the study: the experiences of the adoption process, family metamorphosis, child characteristics, and the social responses to adoption. Under the

experiences of the adoption process major theme, ten sub themes emerged: (A) Comparison of Domestic and International Adoption, (B) Difficulty/ease of Adoption Process, (C) Adoption Characteristics (age of child at adoption, length of time since adoption, length of time between decision to adopt and actual adoption, bringing child (ren) home, conditions of the institution, and child's preadoptive history), (D) Decisions around Adoption (rationale, which children, how many children, which country), (E) Agency Helpful/Not Helpful, (F) Preparation for Adoption, (G) Experiences as Compared to Expectations, (H) Advice to Preadoptive Families, and (I) Overall Perspective. Under the Family Metamorphosis major theme, seven sub themes emerged: (A) Family Roles, (B) Emotional Strain (on primary relationships and individually), (C) Adaptation of Family, (D) Parenting Techniques, (E) Sibling Relationships, (F) Family Resilience, and (G) Connection to Child's Country of Origin. Under the Child Characteristics major theme, five sub themes emerged: (A) Positive Attributes, (B) Negative Behaviors, (C) Child's Personality, (D) Child's Appearance, and (E) Child's Diagnoses. Finally, under the major theme of Social Response to Adoption, five sub themes emerged: (A) Family's Response, (B) Friend's Response, (C) Society's Response, (D) Services Provided, and (E) Adequacy of Services.

Resiliency permeated the participants' stories as they explained what their experiences have been like. The overarching theme of all of the data is that perseverance and uniqueness fosters resiliency in families with special needs. Three domains of family functioning that Walsh (1998) highlights as key aspects of family resilience are: belief systems, organizational patterns, and communication processes. Despite significant hardships and struggles some of the participants in my study endured, they demonstrated their resilience through their beliefs, reorganization of their family, and openly communicating with their family about the struggles. The participant families illustrated multiple factors that protected them from the risk factors that they faced. Some of these protective factors included: faith, religion, social support, preparation before the adoption, parent education, financial resources, and age.

Experience of Adoption Process. The first major theme is very broad in that it uncovers many aspects of the participants' experiences. The first six sub themes that emerged within the larger theme cover the experiences of families prior to the actual adoption. Whereas, the last four sub themes involved a counter-play between their preadoptive experiences and their post adoptive experiences.

Comparison of domestic and international adoption. Most of the participants' reasons for choosing to adopt from Russia or Romania are congruent with those listed in the existing literature as explanations for the increase in international adoptions over the last two decades (Federici, 1999; Goldberg & Marcovitch, 1997; Johnson & Dole, 1999). The reasons that participants discussed that were similar to those in the existing literature included: preference for engaging in a closed adoption process versus an open one, feeling that the foreign adoption would be faster and easier, and wanting to help kids by giving them a home. However, in addition to the reasons listed above, a number of participants listed that their family makeup was a large part of their reason to adopt internationally. It is difficult, if not next to impossible, for single parents and same sex partners to adopt an infant in the United States. In addition, for most states, there is an age requirement that parents cannot be more than forty years older than their adoptive child. Since quite a few of the participants were in their late forties and fifties when they decided to adopt, they would only have been able to adopt an older child from a foster care situation. One study conducted by Price (2002) did report that, for 76.9 % of the participants in their study, the flexibility of adoptive parents' requirements was a key factor for determining from which country to adopt. If adoptive parents' requirements include family makeup and age of adoptive parents, then the findings in my study are also congruent with those of Price's study.

However, it is important to note that when participants referred to domestic adoption, they were all referring to adopting a Caucasian infant. Adopting a Caucasian infant within the United States is much more expensive and requires a much longer wait time than adopting a non-Caucasian infant from the United States. Most, if not all, of the participants felt that adopting from the foster care system was not a viable option for them nor was adopting a non-Caucasian infant. Therefore, participants were referring to the comparison of adopting a child from Russia or Romania to adopting a Caucasian infant from the United States.

Ease/difficulty of adoption process. Another sub theme under participants' experiences throughout the adoption process was the ease/difficulty of adoption process. Only one study, that I am aware of, examined the ease of the American adoption process from Russia or Romania. Goldberg (1997) explored the experiences of eight mothers who adopted from Romania and found varied responses across participants regarding the ease of the adoption process. Some mothers were able to adopt easily on their first attempt whereas, others had adoptions fall through up to five times before they were able to successfully complete an adoption. As

mentioned in the results sections, there was a discrepancy in the findings in this study as well; some participants felt that the process was easy, while others felt that it was difficult. An explanation of this discrepancy is that one's experience with the adoption process largely depends on the agency with which one is dealing. In addition, some of the participants, who had more difficulty in the process adopted over five years ago without going through an agency as there was no agency at that time. It would make sense that as international adoption agencies work with more adoptions and increase their bonds with particular institutions/orphanages, they would have the tools and capabilities to make the adoption process less painful for adoptive families.

Adoption Characteristics. The third sub theme is adopting characteristics and is divided into six categories: Age of child at adoption, length of time since adoption process, length of time between decision to adopt and actual adoption, bringing child (ren) home, conditions of the institutions, and child's preadoptive history. The first of these three categories are descriptive in nature. The age of the children at adoption was a criterion for participation in my study. Therefore, I only interviewed families who had adopted children between the ages of three and five years old. The length of time since adoption ranged from one to eleven years. I think that these findings have interpretative value because the participants' perspectives and the meanings of their experiences were largely linked to the amount of years that their children had been living with them. In fact, I believe that there are developmental stages of the adoption process just as there are developmental stages of all parents raising children (adopted children or biological children). Since I had the benefit of interviewing families at different developmental stages, I was able to place their answers to my questions in the context of their developmental stage. For instance, I noticed that newer adoptive parents seemed to have a more optimistic overall perspective, whereas parents that adopted longer ago seemed to have a more realistic, and sometimes, pessimistic, overall perspective. Also, the developmental stage of the couple relationship seemed to play a role in how well the relationship adapted to the additional strains of caring for (a) special needs child(ren). Participants that spoke about their couple relationship as a resource/strength in their family most often talked about the relationship preparation that they did as a couple prior to the adoption.

The third category was the length of time between participants' decision to adopt and the actual adoption. The majority of participants felt that this time period was minimal, and the

longest period of time was two years. However, this particular participant said that their process was two years because she and her husband spent a long time preparing for the adoption and talking to other adoptive parents. The events that did seem to delay the process seemed to be minor for the most part and/or out of the agency's control. Only two participants were unhappy with the amount of time it took to complete the adoption after they had made their decision. Again, it would make sense that this process would be most efficient if participants were working with experienced and knowledgeable agencies. I have found no other international adoption studies that examine the length of time between the decision and actual adoption to compare with my findings.

The fourth category under the major theme 'experiences of adoption process' was related to when participants actually went to Russia or Romania to retrieve their child(ren). Most of the participants felt that this event was the time during which their agencies were most involved and where participants depended on their agencies the most. Participants talked about what it was like to see their children for the first time, or the traveling arrangements or about the stay with a host family, and still others talked about the pressure they felt to accept or turn down a child once they were actually there. Of course, participants focused their descriptions of these events on the aspects of the experience that had the largest affect on them. Since none of the participants in this study turned down adopting a child once they were in the country to adopt them, I cannot interpret what that experience might be like for people. Of the participants who have had a more difficult time throughout the adoption process, the event of actually retrieving their child does not seem to have contributed significantly to their difficulties.

The fifth category described participants' and my own descriptions of the institutions. As mentioned in the results section, institutions in Romania and Russia seem to be quite different in terms of cleanliness, attachment of children to caregivers, amount of stimulation, caregiver to child ratio, etc. Although researchers have been concluding for years that no institutional setting provides an ideal setting for children to grow up in (Bowlby, 1951; Chapin, 1915; Federici, 1999; Johnson, 1997; Miller, 2000), other studies have reported that as conditions of institutions vary, so do the effects that institutional living will have on the child(ren). However, some researchers report that any kind of institutional living, no matter how good the conditions are, will place the children living there at increased risk for having psychological and emotional problems in the future (Frank, Klass, Earls, & Eisenberg, 1996).

Finally, the sixth category describes what participants know about their children's preadoptive histories. Many of the participants in this study had limited information regarding their children's life before they adopted them. In addition, for those participants who had more information about their children, most were unclear about how to interpret the information that they had. This is congruent with Price's study that stated that many of their study participants (70.2%) reported moderate to extreme difficulty in being able make sense of the medical information they received. They questioned the credibility of the preadoptive records. Some participants in this study even reported that they knew for sure that there was not only confusing information in their child's preadoptive records but that the information was inaccurate. In addition, a few of the adopted children whose parents participated in this study remembered details about their preadoptive life. For these parents, more holes may be filled. It seems that there are many levels where information can be lost, misinterpreted, or not provided. Do the institutions even have the information in the first place? When I was in Romania with the team of doctors, my job on our evaluation projects was to sit with the Romanian translator and translate all of the children's medical records into English. There were very few charts that had anything other than, "abandoned at birth, no information available" or "parents left them at the institution and never came back, no information available on biological family" or "child found in dumpster, no information available." Therefore, the only information that the institution staff had on the children was what they had gathered since the child had been living there. The second level where information could be lost, misinterpreted, or not given is at the agency level. Quite a few participants talked about how they felt that the agency they had dealt with was dishonest by withholding information from them about their children. Finally, the institution where the child resided may have had adequate information, the agency may have received this information and passed it along to the adoptive parents and somehow the information got lost or misinterpreted by the parents. It is hard to know for sure where the problems lie and why many parents are adopting children without having an accurate and complete preadoptive record. But most of the participants in this study either felt that they received adequate information or knew exactly where they thought the problem lay. This finding lends support for the need for prospective parents to research several agencies and find one that they feel they can trust to be upfront and honest with them.

Another aspect of the institutional life for the adopted children, that became apparent across a few of the interviews, was whether or not the child was well liked in the institution. For instance, some participants said that their child was the 'favorite' of the caregivers in the institution and that they felt that this made a difference in the child's adjustment and emotional well-being. This is congruent with the research that reports that while being a 'favorite' in the institution does not significantly affect the prevalence of physical and developmental issues; it does have a significant impact on the prevalence of emotional issues (Price, 2000). Price's study found that children that were more favored at their institution had fewer emotional problems post-adoption.

Decisions around adoption. The fourth sub theme under the "experiences of adoption process" theme centered on the many decisions that surrounded the adoption. Participants shared their stories about how they decided to adopt internationally, which children they should adopt, how many children, which gender they wanted, and from which country they should adopt. They made these decisions through multiple methods including: talking to other adoptive families; discussing pros and cons with friends, families, partner; reading; seeking advice from professionals; following gut feelings; and giving themselves time to mull the decision over. Many of the participants talked about how they were asked to list preferences for the adoption agencies. Most participants felt that their agency had done a good job matching their preferences of gender, age of child, number of children with the child(ren) that they adopted, while others felt that had to be flexible with their preferences. This finding is congruent with Price's (2002) study in which she found that parents reported a high degree of match between their preferences as stated to the agency and the children they adopted. Also, in another study conducted by Price (2000), parents listed the number of children available most often (58.4%), followed by the race of the children (50.0%) as the reasons they chose a particular country. In the current study, participants did not necessarily list either of these reasons as their primary reason for choosing to adopt (a) child(ren) from Russia or Romania. Instead, participants in my study listed reasons such as cost, organization of adoption process, and agency's familiarity with country as the reasons that guided their decision about from which country to adopt a child.

Agency helpful/not helpful. Participants' varied responses regarding whether the agency they went through was helpful or not helpful may be due to the quality of the particular agencies, how long the agencies had been working with the particular institutions from which the parents

adopted (a) child(ren), how much time the agency was willing to spend with participants, what participants' expectations were of the agency going into the process, and the experience parents had with their adoptive children post-adoption. I noticed that new adoptive parents seemed to be much happier with their agency's services than parents who had adopted years ago. This was most likely due to the fact that agencies that have helped families adopt children in the last five years have more experience with these types of adoptions as well as with particular processes of the Russian and Romanian institutions with which they work. Of the participants who were very unhappy with the services the agency provided to them, most of their grievances revolved around feeling that their agencies failed to provide them with adequate information on their adopted children or that the agency was just flat-out dishonest with them. Furthermore, some participants felt abandoned by their agencies post-adoption and were expecting some follow-up services. Hopefully, fewer people are having such negative experiences with their agencies today after having worked with so many adoptive families. It is the agency's responsibility to let potential clients know up front what families can expect from them during and after the adoption.

Preparation for adoption. For the sixth sub theme within participants' experiences of adoption process, participants shared how they prepared for their adoption. As to be expected, there were varying levels of preparation. While some believed that one could never prepare too much, others believed that adoptive parents could over-prepare. Participants prepared through multiple channels including: talking to other parents who had been through the process; reading literature on adoption and post-institutionalized children and their potential special needs; seeking advice from health care providers; making sure that their marriage was in order through counseling or openly sharing concerns and ideas; getting the house ready; preparing siblings of the adoptive child who were already living at home; and/or moving to a larger house or to a better school district.

It makes the most sense that the emphasis need not be placed on the quantity of preparation as much as the quality of preparation. There is so much misinformation on the internet, and so many family and health providers give advice when they have no experience with this population, that it would seem easy to get bogged down with the wrong information. For instance, participants should prepare for the possibility that they will be raising special needs children, but they may not need to search everything on Fetal Alcohol Syndrome until they know that they have a child suffering from that diagnosis. Maybe they just need to know who the good

area health care providers are so that if problems do arise, they know where to take their children. However, participants who seemed to get bogged down in the specifics of possible diagnoses that their future children might be afflicted with seemed to feel that they were over prepared as their children may not have had the diagnoses they read about and may have had completely different diagnoses. At times, they felt like it hindered their ability to see the strengths and normal development of their children because they were so geared up to see characteristics of the diagnoses they studied.

One participant shared that she believes that the two main things that adoptive parents need to get in order before adopting are: their finances and their marriage. She feels that even in the best of circumstances, marriages fall apart and raising (a) special needs child(ren) places additional stress on marriages. In addition, she feels that if adoptive parents have their finances in order they will be more capable of getting their children all of the special services they may need. While I agree that it is important for couples to have their relationships and finances in order, I also believe that adoptive parents should have some level of awareness about potential problems that may arise with their post-institutionalized child(ren); where to get help if needed; and how to best advocate with schools to get their children the services they need. It seems that most parents have a romanticized view of adoption and international adoption, at least before they adopt. Since many of these children may not be "fixable" by love, it makes sense that many adoptive parents as well as the school and health professionals that work with them, are not prepared to deal with the problems. Adoptive parents need to have enough knowledge and information that they can be an advocate for themselves and their children. Also, for parents who are single and adopting, it makes sense for them to know whom they can count on to help them with the everyday tasks of raising (a) special needs child(ren).

The quality of preparation before the adoption takes place seems to be a key indicator of how well families adapt post-adoption. Sar (2000) examined the preparation for adoptive parenthood with a special needs child and reported that overall preparedness, more so than either the number or type of preparation tasks completed before the adoption, was positively correlated with positive evaluation of life, family life, relationship with the adopted child, and less parental stress. In addition, tasks related to learning about the child, family system impact, and disruption prevention were positively associated with family cohesion and marital satisfaction. Groze and Illeana (1996) reported that a significant number of families in their study were considered to be

at risk because they had not had adequate preparation for the adoption. The findings of these studies are congruent with the findings of the current study. Thereby, whether one is adopting a child with special needs domestically or internationally, it seems essential for parents to adequately prepare for being adoptive parents of (a) special needs child(ren).

Experiences as they compare to expectations. The sub theme of how participants' experiences were similar and dissimilar to their expectations included varied perspectives. Some participants reports they had few expectations going into the adoption, while others gave detailed descriptions of their expectations. How well participants' experiences matched their expectations seemed largely linked to how prepared parents were going into the process as well as the adequacy of their agencies' services. One woman who was not a participant in this study but who has adopted fourteen children, three of whom come from disrupted international adoptions, gives the following words of wisdom:

> I am working with the local adoption support groups to prepare parents for the realities of raising a post-institutionalized child. Unmet parental expectations are the real reason that adoptions disrupt. Parents just can't let go of the unreal image of their child, or refuse to change their parenting strategies to handle a traumatized child. It is sad all the way around.

While her words could not be included as part of the results section in this study, I thought it was important to include her words here because it emphasizes the importance of parental expectations and how they shape the experiences of adoptive families. All families will have at least some expectations but it seems important for these expectations to be flexible and realistic. Families that go into the adoption believing that their child will be exactly as they imagined he/she to be, will most likely struggle more with feelings of disappointment. It is okay to have hopes and dreams but those hopes and dreams should be flexible enough for the adopted children to fit into them, just being who they are.

In addition, some participants expected more from their families, friends, and health professionals and were disappointed with the lack of support that they felt from them. Also, some participants expected health professionals and schools to have more knowledge about characteristics of post-institutionalized children. They felt frustrated that they had to spend so much time educating the people around them when the professionals were supposed to be

helping them. When I tell other health professionals about my dissertation topic, I get questions such as; "Why would adopted children from Russia or Romania be any different than normal children?" While these questions frustrate, I am mostly reminded that there is a lack of general education about the special needs of internationally adopted kids from institutional settings. At the very least, most of the children being adopted have some sort of special need, even if they only have language difficulties. One of the main motivations for doing this study was to help with this education process and yet, I know that this is just the first step. The idea that families should be recognized as high-risk is supported not only by the international adoption research (Miller, 1999) but also by a study that compared interpersonal processes of families raising special needs children to those of families without special needs children (Clawson & Bigsby, 1997). This study found that scores on the Self-Report Family Inventory indicated that, compared to families without special needs children, families of children with special needs experienced lower levels of family satisfaction and closeness, higher levels of authoritarian parenting; and the children were seen as less academically and socially competent than their normally-developing peers. Another study identified experiences, concerns, and service needs of families adopting children with prenatal substance exposure (McCarty, Waterman, Burge, & Edelstein, 1999). That study reported that adoptive parents found parenting children with prenatal substance exposure to be more rewarding and more difficult than they had expected. Although the study was examining the experiences of parents who had adopted children with prenatal alcohol exposure from the United States, it supports the finding in this study that many times, participants' expectations about raising their adopted children did not match with their experiences.

Many participants told me about surprises that they encountered during the adoption process. Some participants explained that while their experiences matched their expectations, they still encountered unexpected surprises throughout the adoption process. Some participants felt that they had not encountered any surprises along the way, whereas others listed several surprises. Some of the surprises occurred while they were in Russia or Romania retrieving their child. Other surprises involved finding a biological sibling of their adopted child. The majority of the surprises that participants mentioned seemed to be positive in nature. A hypothesis for why this happened may be that the word 'surprise' has a more positive connotation than the phrase, 'how experiences were similar or dissimilar to expectations.' I am not aware of other studies that

specifically looked at surprises throughout the process of adopting a child from an institutional setting.

Advice to preadoption families. Participants provided a wealth of information when I asked them about the eighth sub theme under 'experience of adoption process': advice for other preadoptive families. All participants gave detailed advice and seemed to enjoy doing so. I got the sense that participants felt empowered and that they had something to offer other families. Advice included things such as: accept the child for who he/she is; gain as much information as possible; get connected with other families going through adoption; get a complete neuropsychological evaluation as soon as you bring your child to the United States; don't forget to follow your heart and enjoy yourself; research multiple agencies so that you can find one you trust; nurture your marriage or partnership; work on your own issues; and seek help from professionals who are educated in this area. Although there are no studies that I can compare and contrast these findings with in the literature, it quickly became obvious to me that these participants really were the experts on their experiences and had a lot to offer other families looking to adopt. I learned so much from these families, and I know that listening to their advice will guide my work with other families.

Overall perspective. The final sub theme under the 'experience of adoption process' theme emerged throughout the interviews because I did not ask a specific question about participants' overall perspectives of their adoption experiences. The interviews seemed to provide a way for participants to not only summarize their experiences for me but also for themselves. As mentioned earlier, resiliency permeated the participants' stories, and I would say that is also true for their overall perspectives. Despite the challenges they've faced and the suffering they've endured, the vast majority of participants did not regret that they had adopted and felt that they and their families had reaped many rewards and benefits. Some of the participants mentioned their faith as an aspect of their overall perspective, stating that, "God does not give us more than we can handle" and "I know we were meant to adopt this particular child" or "we have been so blessed to have the opportunity to have these children in our lives." This faith seemed to fuel their determination and steadfastness to have their family and help their children. Others talked about the ways that they had made sense of their experiences not only as they related to their children but also as they related to their own life course and history.

This sub theme across all of the interviews gave me a sense of how participants felt that they were doing overall as well as where they thought they were headed in the future. In general, participants had fairly positive overall perspectives. Although I did not directly ask participants whether or not they would adopt their children over again if they knew what they know now, I feel I have a sense of what most participants' answers would be. Even the participants who had endured great amount of hardships after adopting (a) special needs child (ren), told me about the blessing that their children were to themselves and their families. I feel very confident that most of the participants in this study, if not all, would adopt the same children again if they knew then what they know now. One study did actually ask adoptive parents this question and received a mean response of 1.18, range = 1, most definitely to 4 = no, would not have adopted (Price, 2000). This study also reported that the strongest predictor of being willing to go back and readopt their child again was the current age of the child. Results demonstrated that the age of the child at adoption was inversely related to how much love parents reported to feel toward their child(ren).

Family Metamorphosis. The following sub themes emerged under this theme including: Family roles, emotional strain on the individual parents and their primary relationships, adaptation of the family, parenting techniques, sibling relationships, family resilience, and connection to child's country of origin. All of the participants and their families have gone through a metamorphosis since the time they first decided that adoption was going to be a part of their lives. Metamorphosis as defined by the Merriam-Webster's online dictionary (2003) is "a marked and more or less abrupt developmental change in the form or structure; a striking alteration in appearance, character, or circumstances." This section of the discussion interprets the different parts of this families' metamorphosis.

Family roles. I asked participants specifically about how they defined their family roles. Most participants described the roles of the partner and themselves, but some also described their children's roles in the family as well as their pet's roles. I also asked how the roles had changed from before to after the adoption. For families who already had children, especially adopted children, these roles did not seem to change significantly. However, for families who did not have kids prior to the adoption, roles seemed to change over time. Some participants did not like the changes or were even surprised at how much their roles had changed, but others just felt like the changes were part of a healthy adaptation to their new developmental stage. The findings of

my study can be related to the findings of another study conducted by Price (2002) who examined family functioning and measured the amount of flexibility families in their study had in regard to relationships and leadership within the family. Most families fell into the flexible category (57.6%), followed by very flexible (18.1%). It seems to me that families that have flexibility in their roles and can readjust occasionally to the new demands placed on them will fare better in the long run. For instance, when a child enters adolescence and is starting to create his/her own sense of autonomy, his/her family needs to readjust roles to accommodate these changes. The same is true for families dealing with a new illness; roles and rules may need to be readjusted to allow for the new demands that the illness will place upon the family.

Emotional strain. The second sub theme under family metamorphosis was emotional strain on individual adoptive parents as well as their primary relationships. Some participants reported feeling depressed and overwhelmed post-adoption; some reported getting sick; while others reported being extremely tired and drained. Three participants went through a separation or divorce post-adoption and felt that the stress of raising a special needs child added extra strain to their marriage and may have contributed to their decision to separate and/or divorce. Participants did not necessarily blame the fall of their relationship on the adoption or raising a child with special needs, but felt that their relationship was negatively impacted by the additional stress, drain of resources, and different ideas for how to deal with and perceive their children's special needs. An interesting article by McCarthy (2000) compares postpartum depression to post-adoption depression. The term post-adoption depression was coined by Bond in 1995. McCarthy reported that of the 145 parents who responded to her survey on post-adoption depression, 65% said that they had experienced post-adoption depression. However, only 8 of those people reported that they had been advised by their social workers or agencies that post-adoption depression was a common syndrome experienced by adoptive parents (especially parents who adopt internationally from institutional settings). Sixty one percent of the respondents said that they would have found it helpful if agencies had prepared them for this possibility. McCarthy thinks that adoptive parents of Eastern European children are at particular risk for depression because, in most cases, they are not adopting newborns, and they are dealing with grief over the loss of unknown histories and missed bonding opportunities. She also contends that parents often discover disturbing surprises about their child after the adoption has taken place. All of these stressors add to the other existing stressors felt by adoptive parents

including: Potential grief over not being able to conceive a biological child, unrealistic expectations driven by their hopes and dreams of what their family will be like, guilt over not bonding or loving at first sight, etc.

Lastly, McCarthy (2000) compared the time that parents normally suffer from postpartum depression to the amount of time parents suffer, on average, from post-adoption depression. She reports that parents suffering from postpartum depression may only be depressed for a short duration of less than two weeks. Whereas, 77% of the participants in her study suffered from depression symptoms for a period of two months to over one year, with 45% suffering for six months or more. Another study examined parenting stress due to adopting from Romanian institutions and found that the strongest predictor of parenting stress was the extent of the child's behavioral problems. In subsequent sections, I will discuss how emotional and behavioral problems seemed to have more detrimental effects on families than medical or learning problems.

There are conflicting findings in the special needs literature about whether divorce is higher in families raising special needs children or children who are chronically ill. However, most studies have demonstrated the greater stress on parents and their relationships when they are raising a child with special needs. The participants in my study who reported that their marriage or partnership was still intact also reported that the relationship had been tested or, at the very least, stressed. However, most parents raising children undergo a certain amount of stress whether raising biological children, adopted children, children with special needs, or children without special needs. So, the question is whether or not raising (a) special needs child(ren) adds additional stress to parents' significant partnerships. Most of the participants in this study would say that it does, while others would say that they do not believe their relationship underwent any more stress than it would have had they been raising a biological child or a child without special needs.

Adaptation of the family. The next sub theme, adaptation of the family, demonstrated how participants and their families adapted post-adoption to raising a child or children with special needs. The participants all adapted in unique ways, and there are as many differences in their process for adapting as there were similarities. Fortunately, most families had adapted, and, by the time I interviewed them, they felt that while they might still have be working out issues, they had adapted and were adapting successfully. This lends support for the idea that parenting

should be dynamic and constantly adapting over time versus becoming static. Also, it is important to remember that adoption is about more than the way that the child joined the family but is an event that affects the way in which child(ren) and their families perceive themselves. Their perception of themselves as a child, a parent, a family develops over time as they adapt to their new family makeup. The findings of this study regarding family adaptation are congruent with the findings of Price's study that also examined family adaptation (2002). Family adaptation in Price's study was defined as assertiveness, leadership, discipline, negotiations, roles, and rules. Price reported that families ranged in scores on adaptability from 36, meaning they were very rigid, to 63, meaning they were very flexible, with a mean of 48.98. Therefore, most of the families who participated in that survey research were also adapting well.

   <u>Parenting techniques.</u> Parenting techniques was another sub theme that emerged from the interviews. Participants shared stories for how they had parented their child(ren) and explained what seemed to work well and what did not. Most families reported to care a great deal about being consistent with their children, enforcing rules, and following through with logical consequences for not following the rules. For the most part, participants felt that providing a consistent structure for their children was the most effective parenting technique. Participants varied, however, with how comfortable they felt providing this consistent structure, and some explained that having strict rules and being consistent were in direct conflict with their personality. As per the participants' report, those who were in significant partner relationships explained that there were periods of negotiation about what the rules should be and who should be the disciplinarian. They did not always agree on who was the more effective disciplinarian.

   In addition to providing structure for their children through rules, consistency, routines, and consequences, some participants also shared how they felt they handled the softer side of parenting. They would talk about how they would hold their children accountable for their actions while simultaneously reinforcing that they loved and accepted their children. This strategy of balancing the soft and tough sides of parenting is discussed frequently in the literature and is supported by professionals who have worked with post-institutionalized children or children with attachment issues (Federici, 1998; Thomas, 1997). Also, participants whose child(ren) were suffering from attachment issues reported using holding techniques with varying effectiveness. The extent to which participants felt this was in their nature as a parent also varied. Finally, some participants explained that they have been trying to help their child(ren) develop

interdependence and to enable them to develop their own sense of self and set of talents, especially as the children were moving into their adolescent years. Edwards (2002) wrote about a similar process in her article entitled "Attachment, mastery, and interdependence: A model of parenting processes." She discussed the important roles that parents play in helping their children develop interdependency in their relationships.

Sibling relationships. Another sub theme that emerged under "family metamorphosis" was sibling relationships. Just as parent-child relationships formed and developed over time, so did the sibling relationships. Some participants had only adopted children who were biological siblings from the same orphanage, while others adopted what are called, "psychological siblings," -- not biological siblings but who grew up together in the same environment/orphanage and spent all or most of their lives together. There were also some participants who had adopted all of their children from Russia or Romania, but the children may have grown up in different orphanages or different circumstances. Other participants had adopted domestically and then decided to adopt internationally, and so all of the children could share the story of being adopted but may have been adopted from different situations. Finally, some families already had a biological child or biological stepchildren and then decided to adopt from Romania or Russia as well. Although I did not study sibling relationships in depth, it seemed that sibling relationships were closer among siblings who could share a similar story or background than siblings who could not. For instance, I talked to one adolescent who was the biological child of one of the participants and who has two adopted siblings from Russia before I interviewed his mom. He talked about the anger and resentment he had felt for many years post-adoption because he felt like so much of his mom's attention was directed toward his siblings' special needs. Although I could not share his testimony in the results of this study, it was interesting to hear his perspective. Other participants also talked about the sibling rivalry that occurred between siblings, especially siblings from different backgrounds. More research should be done on how siblings of post-institutionalized children are affected by the increased focus on their siblings' special needs.

Family resilience. As I mentioned earlier, families who participated in this study demonstrated great amounts of resiliency, and so not only was it an overarching theme across all of the interviews, but it also was a sub theme that emerged under "family metamorphosis." I asked participants which of their family's strengths had helped them adapt to and deal with

raising a special needs child. All of the participants could answer this question easily. Some talked about their strong religious faith, the support of family and friends, the strength of their marriage or partnership, their outlook on life, how well prepared the felt going into the process, the strengths of the child(ren), their willingness to keep working and not give up, and the amount of emotional work they had done themselves before beginning the process. The strengths of the families in this study are great, and there is no doubt that these strengths have helped them endure their struggles and hardships.

  <u>Connection to child's country of origin.</u> The last sub theme under family metamorphosis dealt with how participant families maintained a connection with their child's country of origin. In general, participants seemed confused about how much and even how to integrate their children's cultures into their family lives. Some participants did not even think this was an important aspect of their family's adaptation, while others knew it was important but weren't sure how to go about doing it. A few of the participants were not confused and seemed to be integrating culture as best as they could and felt that they were doing an adequate job. They focused on helping their child (ren) maintain a connection to his/her country of origin by having Russian or Romanian decorations up in their home, having discussions about the culture, participating in activities with other families who had adopted a child(ren) from Russia or Romania, etc. However, the majority of participants, whether they were actively integrating their child's culture into their family life or not, reported that they allowed their children to talk about any memories they had of their preadoptive lives. In a 2002 article for the FRUA newsletter, Gray (2002) discussed the impact of cultural change on attachment. She stressed how important it was for adoptive parents to learn about normal child development in their children's cultures. She gave a number of examples to explain why it is important for parents to talk to children about their cultures and their countries of origin--especially when the children had questions. She described that typical questions might be: Why did my country not want to keep me? Why do they treat children so poorly in the orphanages? Do the people in that country know what is happening in the orphanages? Gray contends that it helps children to know that most people in the country do not know how the children are being treated in the orphanages or that parents are so poor that sometimes the only way they know their child will get fed is to let them live in an orphanage. A piece of one of my journal entries talks about the economic state of

Romania and how my feelings toward the country changed as I spent more time learning about the country's economic hardships:

> I spent many of the first few days feeling very angry at the whole country of Romania for not taking better care of their children. But one night, as my own sense of inadequacy and helplessness lessened, I experienced a small shift. One evening, after spending the day in the *camin spital*, we encountered a group of sewer kids, children who literally lived in the drains and gutters of the streets. But ironically, though these children didn't even have a roof above their heads, and would have longed for the beds that the children in the incurables hospitals had, they were amazingly strong, smart, and resilient. These were children who were finding ways to survive in the most terrible circumstances. They might be hungry and dirty, but they had more resources, personal and otherwise, than many of the children in the hospitals did. And from this I also began to realize that the Romanians were not neglecting their children from selfishness, but simply because survival itself was so difficult for everyone. Who could care for a child if they could not care for themselves?

Child Characteristics. The third theme across the data was child characteristics. As mentioned earlier, all of the participants in this study had adopted children with at least some special needs. Participants did a great job on their own of balancing what they believed their children's special needs to be with what they felt were their children's positive attributes. Under this theme emerged five sub themes: Positive attributes, negative behaviors, child's personality, child's appearance, and child's diagnoses.

Positive attributes. The first sub theme was positive attributes participants described about their children. Some of these positive attributes included athleticism, strength, intelligence, courage, a sense of humor, musical talents, and artistic talents. In fact, participants seemed to be able to report their children's strengths as easily, if not more easily, than they were able to report their weaknesses or areas of concern. This finding is congruent with Price's (200?) study, in which she found that 72.8% of the children were reported to have above average abilities in one or more areas. The children in Price's study were similarly recognized for their talents in overall intelligence, athletics, language, music ability, and art. In both my study and Price's study, parents were able to describe their children as whole people; people who have strengths and

weaknesses. From my own experience in working with children in both a non-clinical setting (swim team practices) as well in a clinical setting (therapy office), I have noticed that often times, the children who have special needs are also the ones who also present with special talents.

Negative behaviors. The second sub theme that emerged under "child characteristics" was negative behaviors of children as perceived by their parents. Negative behaviors ranged from manipulative behaviors and tantruming to hurting animals or other children. Most of the participants had dealt with behavioral concerns for at least a portion of time post-adoption. This is not surprising given the research stating that post-institutionalized children are more prone to behavioral and emotional problems as well as developmental and learning difficulties (Federici, 1999; Hoskbergen, 1997; Pavao, 1998; Rhodes, 1997). Unfortunately, the participants in this study who seemed to be struggling the most had significant behavioral concerns for their child(ren). This finding is also congruent with Price's 2000 study, which reported that parents' stated willingness to adopt again knowing what they know now was largely related to the number of emotional and behavioral issues their children were having. Likewise, Mainemer, Gilman, and Ames (1998) reported that the strongest predictor of parenting stress was child behavioral problems.

Child's personality. Although I did not directly ask participants to describe their children's personalities, most participants ended up doing this during the interview. The overwhelming majority described their children as strong willed or determined and sometimes even oppositional. Most had attributed meaning to their child having this type of personality by explaining that it resulted from living in an institution and having to learn ways to survive. As several participants stated, "there are so many kids; no one is going to really watch out for the kids, they have to learn to watch out for themselves." The participants who did not necessarily describe their child as strong willed and/or stubborn described their children as easy going, fun, and very loving. It does not seem appropriate for me to interpret why the children whose parents participated in this study had the personalities they did as I have no way of ascertaining if each child's personality was determined largely by prenatal, preadoptive or postadoptive factors. However, some of the participants who described their children as having determined and stubborn personalities reported that caregivers in the institutions where they adopted their children from had also told them that their children were strong willed/stubborn.

Child's appearance. The fourth sub theme under "child characteristics" was how participants described their child's appearance. Interestingly, quite a few participants said nothing at all about the appearance of their child. Those who did seemed to give me a description in order to explain how it related to something else. For instance, some participants felt that their children looked like them, and they felt this prevented people in society from picking their children out as being adopted. Other participants mentioned their child's appearance in reference to his/her medical problems or emotional problems, while others focused on how innocent/sweet looking their child was and explained that the child's appearance made it hard for others to believe that the child could ever do anything wrong or manipulative. I had the advantage of seeing most of the children whose parents were participants in my study, and I noticed that the majority were very attractive children.

Child's diagnoses. Finally, child's diagnoses were the last sub theme under child characteristics. All of the children whose parents participated in this study had at least one medical, developmental, emotional or behavioral diagnosis, suggesting that all of the children adopted by participants in my study had some sort of special needs. Parents, and reportedly school professionals, seemed to have the greatest difficulties in dealing with behavioral and emotional diagnoses. Emotional and behavioral concerns often are virtually impossible to confirm prior to adoption and then are not identified until some time after the adoption as children's development is observed longitudinally. There can be more blame attached to emotional and behavioral diagnoses for the family than more traditional 'medical' diagnoses. Shame and guilt often accompany blame, even if the adoptive parent knows rationally that the child came with existing baggage and had experienced significant trauma before the adoption took place.

Social Response to Adoption. There are five sub themes that emerged from this theme including: Family response to the adoption, friend response to the adoption, society's response in general to the adoption, services provided for family post-adoption, and adequacy of those services.

Family response. Participants seemed to have either really positive experiences with their families or really negative experiences, but there were not too many in-between experiences. A few participants, however, felt that their families were not very accepting of the idea of adoption at first but came around and were supportive at the time of the adoption and afterwards. An interesting aspect of this finding was that those who felt that their families had been supportive

claimed that their support played a significant role in their family's adaptation and resilience. However, when participants did not feel that their families had been supportive, they claimed that that lack of support was one of their biggest struggles throughout the entire process. In addition, most participants reported that some family members were more supportive than other family members. These findings can be compared to those of another study conducted by Price (2002), which reported that, prior to the adoption, most families were very supportive (58.4%), and only 3.4% of families were not at all supportive. After the adoption, even more families were reported to be very supportive (84.6%), and only 1.3% of families were reported to be not at all supportive. Although the current study did not break down on a likert scale how supportive families were to participants, over half seemed to feel that their families were either very supportive or somewhat supportive. Less than a third felt that their families had been completely unsupportive and those participants felt that their family was more unsupportive of them as parents than of the adoption itself.

Friend response. The next sub theme was friend response. Some of the participants reported that many of their friendships had changed. This seemed especially true for the single parents and same-sex parents. They felt a lack of acceptance among many of their friend's of their new roles as parents. In other words, their friends seemed unwilling to recognize that their top priority was now their children. Some of the married participants reported that not all their friends respected their rules and the consistent structure that they were trying to provide for their children, and so they decided to cut off their friendships with those people. This seemed especially true for the participants who had adopted children with behavioral and emotional problems. Over half of the participants, however, reported that their friends were an important resource and source of strength for them and their families, and they felt that their friends had tried to be as supportive as they could be. Price (2002) also examined the support from friends that the participants in her study felt and found that the overwhelming majority reported having supportive friendships before and after the adoption. As stated earlier in this paper, children adopted from Eastern European institutions are recognized as an at-risk population. With increased risk factors for these children and their family, researchers and clinicians need to examine the protective factors that help them be resilient. Adequate social support seemed to be an important protective factor for the families in my study and greatly contributed to their resiliency.

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Society's response in general. I also asked participants about how they felt about the general societal response to their adoption. The majority of participants remembered times when they were at a store or at school or a doctors office, and someone would make what they considered to be an insensitive comments such as, "do you know anything about their real parents?" They also reported that their children were asked at school to bring in baby pictures even when the teachers knew the children were adopted. The described instances when people asked their kids if they are adopted since they don't look similar to their mothers. In general, participants seemed to remember times when people seemed to have not thought before they spoke. Participants did not seem to necessarily hold grudges about these incidents, but they felt that schools and doctors offices should more effectively leave space for different types of families and different child histories. Wager authored an article in *Family Relation* in 2000, which she discussed the social stigma attached to adoption and listed suggestions for how to erase negative bias from adoption research. She concludes that the failure to recognize the stigmatized social position of adoptive families has shaped adoption research, practice, and public opinions about adoption. Although Wager seems to be primarily talking about domestic adoption, it is logical to assume that the same social stigma is attached to Eastern European adoptions. Again, this can be seen as a risk factor for parents adopting children from Eastern Europe. However, the majority of the participants in my study seemed to have developed 'thick skin' for dealing with the social stigma. In my opinion, this 'thick skin' served as a protective factor for them and fostered their resiliency.

Services provided. The fourth sub theme, services provided to the child, was more descriptive in nature. Almost all of the participants and their children were receiving some type of special services, whether they are psychiatric services, speech and language services, medical services, occupational therapy or an IEP. All of the participants took their children to their pediatricians yearly for their annual checkups. Therefore all of the participants were able to answer the research question regarding the type of services their family had received and the adequacy of those services. In general, most participants spent a great deal of time running their child from specialist to specialist. Some even mentioned that they switched from working full-time to part-time just to get their children to all of the necessary services. Also, quite a few of the participants shared that they had sought the guidance of many helping professionals while

looking for "the answer" that could make things better, while others seemed to try everything they could to not use resources and would only access them as a last resort.

Adequacy of services. The last sub theme related to adequacy of services provided to the families. Most of the participants seemed to have "done their homework" in a sense because they had had bad experiences with health and school professionals and had since found professionals that were better meeting their needs. Participants were most disheartened when health and school professionals failed to validate or believe their experiences. They felt that the professionals were blaming them for their children's problems and sensed a lack of education on the part of the professionals about the needs of post-institutionalized children. Some participants even talked about having a list of three or four questions that they asked professionals in their first meeting, and if they did not answer their questions directly, they left the office. They did not feel that they should have to be educating the professionals about how to help them. For as many negative stories that participants had to share about health and school professionals, there were an equal number of positive stories. In general, the families living in Northern Virginia seemed to have more services that understood the special needs of this population available to them than either Wisconsin or Central Virginia families did. Most participants had developed a unique ability to detect whether or not a health professional knew what he or she was doing. Some said that they wished that professionals could just say they did not know something when they didn't and be willing to learn about it. A few participants mentioned that they had stayed with a pediatrician that originally did not know about the effects of institutionalization because he/she was so willing to learn about it.

The vast majority of participants felt that professionals in general should more effectively educate themselves about the needs of post-institutionalized children. There are several ways that health professionals can increase their level of awareness and education about the needs of post-institutionalized children: They could attend seminars that discuss the effects of living in an institutional setting, conduct their own research or read the existing research on post-institutionalized children, ask parents who are raising a post-institutionalized child about their concerns and not be afraid to learn from the families themselves, and they can ask other health professionals who do have knowledge and expertise in working with this population to collaborate with them.

More than any with other area, almost all of the participants had struggled with the schools that their children attended, especially when the school was a part of the public school system. In general, most of the participants felt that they had to constantly advocate for themselves and their children to get them the services that they needed. In some cases, an IEP had already been developed for a child, but the participants felt that the schools were not following through with the IEP guidelines. However, participants' major complaint was that the schools did not believe that the child needed special services and even thought that the parents were making up the child's problems. The participants who had children with behavioral and emotional concerns seemed to have the most difficulties with the schools. There were some participants who did feel good about the work that their child's school was doing with them, but they had heard horror stories from other adoptive parents and felt blessed that they were not having similar issues. Several participants had sought out private schooling and were very pleased with those arrangements and with how well the school was handling their child's special needs.

<center>Limitations of the Study</center>

Although this study opened the door for examining the experiences of parents who adopt children from institutional settings in Russia or Romania, it is limited in it's generalizability by the demographics of the participants. Although there was diversity in the type of family makeup, all of the participants are Caucasian. In addition, all of the participants are of middle to upper socio-economic status and are educated. However, in studying the Eastern European adoption community, it would be next to impossible to gather a sample that covered all other racial backgrounds and a lower socioeconomic status. In general, adopting internationally is expensive, and even for families who do have many financial resources, getting the needed services for their children may drain their financial resources significantly, as evidenced by the words of many of the participants in this study. It is also important to consider this group of adoptees (children adopted at ages 3 to 5 years of age from institutions in Russia or Romania) as among the highest risk among international adoptees, often with significant preadoptive experiences that may impact on both the child and family's adjustment post-adoption.

Another limitation may be the sampling bias, as adoptive parents who were eligible for this study but did not respond to my request for participants. The participants in this study were self selected and are possibly not representative of the population under study. They were parents

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that had specifically adopted from Eastern Europe and were highly motivated, responding parents. There were many other adoptive parents who asked to participate in this study but who did not fit with the study criteria. Finding a representative group is not necessarily the goal of qualitative research, but not having done so is still a limitation of this study and of qualitative methodologies overall. It could be that the participants in this study do not represent the average experience of families adopting from Russian and Romanian institutions. Perhaps the adoptive parents who chose to participate were having such positive experiences that they wanted to share them; on the other hand, they may have wanted to share their negative experiences. Whatever the case, the participants were sharing their perceptions of their experiences at the time of the interview but it is important to acknowledge that the adoption process is lifelong and dynamic. In other words, if I interviewed the same participants at some point in the future, there would most likely be at least some changes in their perceptions.

Recommendations for Future Research

Since this was an exploratory study that covered many aspects of the adoption experiences of the participants, there are many avenues that other research studies could pursue. For instance, a future study could conduct a comparative analysis of all of the domestic adoption literature to the findings of this study. How do families adopting a child from the United States compare to families adopting from Russia or Romania? How do children who have lived in the foster care system prior to their adoption adapt differently or similarly to children adopted from institutions? How do adoptions from Russia or Romania compare to adoptions from other countries? I wanted to limit the focus of this particular study to the experiences of parents who adopted from Russian or Romanian institutions, but I do recognize that there are most likely similarities between their experiences and those of parents who adopt children from the United States, especially from foster care. From understanding and interpreting the results of this study, I will be better able to conduct future studies that will compare the experiences of these parents to other parents, whether they are other international adoptive parents, domestic adoptive parents, or parents raising their biological children.

Another recommendation for future research would be to examine any of the major themes or sub themes in greater detail by either conducting case study research of a few families or by gathering a larger, more representative sample and conducting survey data and then

analyzing it through statistical methods. In addition, the criteria for participating in this study were very specific, and so it would be important to do follow up research on other families who did not meet this study's criteria in the Eastern European adoption community to understand whether their experiences are similar or different. There is so much research that could and should be done in the area of international adoption and families adopting post-institutionalized children, and this study, in my mind, should be seen as a stepping-stone for future studies.

Finally, there is always a strong need for research that evaluates the efficacy of existing forms of treatment for families and children dealing with the issues mentioned in this study as well as efficacy research on new and alternative forms of treatment. Pre- and post-adoptive parents and health care providers alike need a better understanding of what works longitudinally for post-institutionalized children and their adjustment.

<div align="center">Clinical Implications</div>

On the basis of these findings, at least a portion of parents who have adopted children from Russian or Romanian institutions when the children are at the toddler age feel isolated, misunderstood, and unsupported by health professionals. This means that health professionals have room to grow and improve in their skills for meeting the needs of this population. Not only from the findings in this study but also from my own experiences as a mental health professional that cares about these children and families, I know that a tendency is there to either avoid or deny the existence of problems. One reason I believe I did not begin having nightmares until almost two years after I returned from my trip to Romania is because I repressed many of the memories of my time in the institutions. It was very difficult to make sense of what these children were experiencing and still continue living my life, which as compared to their life, is very privileged. A number of the participants in this study reported feeling blamed by health professionals and school professionals. Maybe they felt blame because the professionals could not, themselves, make sense of the data before them and had therefore decided that the parents must be fabricating stories, or perhaps they worked off the basic premise that parents are to blame for their children's problems. Regardless of why health and school professionals failed to validate or believe adoptive parents experiences and trust their thoughts, I can't think of anything more counterproductive or harmful. Therefore, I believe it is extremely important that health professionals not only become educated about the special needs of post-institutionalized children but also learn to listen and trust parents and validate their experiences. Parents can be the greatest

resource for gathering information about clients' lives so that professionals trying to help them can make sense of their current problems.

I think that when a situation or problem becomes extremely complicated, as in the cases of many of the participants in this study, it also becomes easy as well as tempting to place blame on someone or something. Not only did a number of participants feel blamed by the health professionals and the schools but I am fairly confident that providers have also felt blamed by families for not being able to adequately meet their child's needs. This becomes an unfortunate situation all the way around and does not help the child get what he/she needs. In fact, the child is sure to be affected by the conflict that surrounds them. Comer, Haynes, Joyner, and Ben-Avie (1996) designed a protocol for reforming education in the United States. One of their three guiding principals is the 'no blame' principle. The intent of this 'no blame' principle is to focus on problem solving and to operate on the premise that other peoples' mistakes are a result of misunderstandings, misinterpretations, and miscommunications versus a deliberate attempt to offend (p. 57). The writers contend that accountability should be accepted by the whole team (parents, child, school professionals, outside providers) and that by blaming, people are avoiding self reflection and thinking about their part in the process. Blame undermines collaboration which all of the participants mentioned would be helpful to them and their families.

In addition, health professionals need to be able to recognize that there are potential stressors that might affect the lives of families adopting from Russian or Romanian institutional settings that may not exist for other families. For instance, even the most prepared of families may not have had any way of knowing about the special needs of their adoptive children and how much caring for their children could drain their emotional, financial, and social resources. Health professionals need to be sensitive to these realities and to come up with ways to help clients alleviate the stressors and determine appropriate coping mechanisms for dealing with them.

If mental health professionals choose to work with families who have adopted children from institutional settings, they need to have appropriate tools and skills for dealing with these children. For instance, as a number of the participants in this study so eloquently stated, play therapy may not be the most appropriate therapy for children with Reactive Attachment Disorder (RAD). Mental health professionals working with these families need to be able to 'think outside of the box' and look at what works and even be willing to ask other families who have

successfully helped their child adjust and become healthy individual how they did it. Traditional family therapy theories may help with the conceptualization of what is happening in these families, but they may not be suffice for providing interventions for families struggling day to day with how to keep their children and families safe. However, much of what participants said worked for them in parenting their child (ren) was congruent with structural family therapy and more specific, the circumplex model developed by Olson (Walsh, 1993). Structural family therapy focuses on boundaries, subsystems, and structure and the circumplex model has three central dimensions for families and couples: cohesion, communication, and flexibility. The idea that families who are balanced on all three dimensions will have healthier functioning is the major hypothesis of the model. When I asked participants in this study what seemed to work for them they frequently mentioned things like being flexible, effectively communicating, providing structure, etc. From this finding, I conclude that structural family therapy should be a component for effectively working with adoptive families.

However, it is important to mention that many alternative/new forms of treatment have not been evaluated for efficacy. Not to mention, many times, the treatments are costly. Therefore, parents and the health professionals need to be careful to not jump so quickly that they spend their money on treatments that have no clear indication of effectiveness when their money could be used on treatments that have been shown to work over the long term.

Kozlowska, Mibbs, and Hanney (2002) discussed the integration of attachment and family systems theories. The authors contend that network thinking requires that clinicians hold multiple perspectives in mind, considering each system level as both a part and a whole, and shift the focus of attention between levels (p. 285). I like this article because it demonstrates how attachment theories and family systems theories can work in conjunction with one another. It is particularly important that therapists working with post-institutionalized children understand and use both theories. It makes sense to me, as a clinician, that if many of these children are struggling with attachment issues; it is counterproductive to work with the child alone all of the time and not the family. The child needs to securely attach to their adoptive families and a family therapist could be a conduit for this process. For instance, filial play therapy may serve as an appropriate treatment option. Filial therapy helps the child(ren) and parent(s) learn to play, communicate effectively, problem solve, understand feelings, and build trust as a family (Rye, 2003). Unfortunately, many marriage and family therapists and other mental health providers are

not trained in filial play therapy. Therefore, mental health providers working with adoptive families should think about getting trained in filial therapy.

Also, since so many of these post-institutionalized children are dealing with language problems (developmental language disorders in addition to ESL language difficulties), therapists need to educate themselves about language disorders and be willing to collaborate with speech and language specialists. In general, health providers should take the time to research and learn about the multiple diagnoses of post-institutionalized children. As one participant said, "I get tired of having to constantly educate health professionals about my child's diagnoses. They are the ones supposedly helping me!" While I believe that a therapeutic relationship should be negotiated between client(s) and therapist and that the client is just as responsible for "doing the work," I believe that the therapist needs to be equipped to offer the clients something different than they can offer themselves. In addition, therapists need to be prepared to advocate for these families in order to assist them with obtaining the services they need and be willing to collaborate with other health and school professionals providing care for them.

Finally, there is plenty of space for health professionals, especially therapists, on the front end of the adoption to consult with adoption agencies and help prepare adoptive families. Since parents are sometimes disappointed with the lack of follow through with agencies after the adoption is complete, therapists can contract with agencies to provide post-adoptive services as well. After all, in the case of domestic adoptions, pre and post-adoption services are not only provided but required. I believe there should be a similar policy for international adoption. Also, since a family's adaptation and level of stress post-adoption seems to be linked to overall preparedness of the adoptive family, it makes sense that therapists can aid in the preparation process. There is also room for collaboration with the social workers doing the preadoption home studies and therapists could go in at the same time with the social workers and offer five to seven therapy sessions. These therapy sessions can help families prepare together for their new member(s) and their transition into a new life stage and/or family life cycle stage. As one participant couple mentioned, preadoption therapy helped them to get on the same page (as a couple) about the adoption and they attributed some of their successful adaptation post adoption to the fact that they were working together. Not to mention, a number of participants had been through infertility treatments and had to endure the loss of not being able to conceive. As the infertility literature suggests, this is a big stressor on couple relationships. Preadoption therapy

could address any unresolved grief over these issues. Therapy could also serve to help families identify existing strengths and resilience so that if and when problems arise post-adoption, they may be able to locate their strengths quicker and build upon them. This process, which could be called preadoption counseling, would be similar to premarital counseling or birthing/parenting classes that parents conceiving a biological child attend. Family strengths, areas of concerns, and coping strategies could be identified. Psychoeducation should be another primary focus for marriage and family therapists and their involvement with adoptive families. They can provide parenting classes, child developmental classes and classes on stress management. In addition, preparation can include basic information on common diagnoses that adoptive children have, what symptoms/signs to look for, and what resources are available for treatment. I do not think that preparation should include detailed information about all the possible diagnoses that adopted child (ren) may have as this would probably serve to overwhelm preadoptive parents. Finally, if a marriage and family therapist is involved from the beginning of the adoption process then when families have problems post-adoption they will already be connected with a therapist they trust and won't need to go through the added step of finding help.

In general, I believe that a therapist working with post-institutionalized children and their families need to be open to new forms of treatment, be willing to research the efficacy of the new treatments, as well as be willing to collaborate with other professionals who have experience working with post-institutionalized children. The best kind of marriage and family therapist for these families is the kind who is willing to recognize the expertise of the other providers as well as the families themselves, and work as an involved team member.

Conclusions

In conclusion, participants had many similar responses to some of the research questions, but overall, some of the participants seemed to have fairly positive experiences throughout the adoption process, whereas others seemed to have more difficulties. This may be partially related to the length of time families were post-adoption at the time of my interviews. Also, for several participants whose experiences seemed congruent with their initial expectations, preparation prior to the adoption seemed important. By preparation, I mean talking to other adoptive families, doing their own research, and exploring different agencies and resources before the adoption. In the case of participants who did not feel that their experiences had been congruent

with their expectations, they said that they wished they had educated themselves more about what they could realistically expect as well as spent more time finding people they could trust before the adoption.

The findings of this study should be disseminated to health care professionals, families who have adopted, and families planning to adopt. Health care professionals need to have a better understanding of what these families deem as helpful and not helpful. They also need to be more educated on the types of conditions and problems that they can expect to be dealing with when working with an international adoptive family. Likewise, the findings of this study can serve as a source of validation for other adoptive families as well as highlight the importance of this validation in making the whole adoptive process easier.

Finally, the participants explained that either preparation for what to expect before the adoption helped them throughout the process or that more preparation would have helped them. Therefore, it appears that it would be important for researchers to conduct research that allows this population to continue telling/sharing their stories so that other families planning to adopt can understand what international adoptions entail.

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Appendix A

Invitation Letter

Dear Potential Participant,

I am writing to invite you to be a participant in my study entitled, "International Adoption: Family Experiences Concerning Adopting a Child from Russia or Romania." Within this study I will aim to understand the adoptive families' experiences and how they are similar or dissimilar to their expectations. In addition, this study will gain information on how health professionals can work collaboratively to meet the adoptees' and their families' medical and psychosocial needs. I am looking for adoptive parents who are willing to participate in a two-hour (maximum) interview with me, the principal investigator. Upon transcribing and coding your interview, I may ask for permission to contact you for some follow-up questions.

By participating in this study, you will be helping me and other health care professionals to better understand your experiences as a parent of a child adopted from Russia or Romania as well as how we can better meet your families' needs. Upon completion of my analyses, I will share my findings with you before publishing or disseminating the results to other health care providers. If you are interested, please read the introduction packet, which will give you more detailed information on the project. In addition, please read the informed consent form to be sure of your rights as well as the potential risks and benefits involved when participating in this research. If you have any questions, feel free to call me at (703)587-3503 or e-mail me at **dlinvill@vt.edu**. Thank you in advance for your time.

Deanna Linville, M.S.

Appendix B

Information Guide for Participants

Project Title: The Experience of Families who have Adopted a Child at Least Three Years of Age from Russia and/or Romania: A Qualitative Study

Principal Investigator: Ms. Deanna Linville, Doctoral Candidate in the Marriage and Family Therapy Program, Department of Human Development

Purpose of the Study

Several studies have identified risk factors for internationally adopted children with respect to emotional, cognitive, developmental concerns, but few studies have either determined the affect of the institutionalization on the children and their families or identified protective factors for families adopting Eastern European children of toddler age or older. Although many clinicians have suggested treatments and resources for these children and families, little research has examined the experiences of adoptive families from these families' perspectives. Lastly, there have been quite a few researchers who have examined the medical aspects of diagnosis and treatment of international adoptees, but have not, in conjunction, examined the psychosocial aspects. This study will aim to understand the adoptive families' experiences and how they are similar or dissimilar to their expectations. In addition, this study will attempt to gain information on how health professionals can work collaboratively to meet the adoptees' and their families' medical and psychosocial needs. Therefore, this study will provide a first step toward understanding the adoption process experiences of families who have already sought neuropsychological consultation for an adopted Russian or Romanian child of 3 years of age or older.

My primary goal is to determine and depict the subjective reality of the adoptive parents and how they perceive their experiences with adopting a child from Russia or Romania. While attempting this task, I must also keep in mind the shifting aspect of their experiences as the participants will grow and change over time in their thinking about themselves, their families, the adoption process, and their experiences. Another of my goals is to understand how participants perceive the care they received from mental and medical health professionals and ways they feel

these professionals can be more helpful. In addition, I will disseminate my findings to other health professionals, mental and medical, so that they can better understand this population.

Procedures

Qualitative interviews will be conducted, transcribed, coded to find meanings and themes from the 20 families' stories. Interviews will continue to be conducted until data is theoretically saturated. Each interview will last approximately 2 hours or until the participants choose to end the interview session. Married couples will be interviewed together while single parents will be interviewed individually. In some cases, only one member of a married couple may be available for the interview, but both members of the couple will be asked to review the transcript for accuracy. Parents of the international adoptee(s) will be the only family member(s) interviewed. No children will be interviewed. In addition, the researcher will conduct some interviews in the homes of the participants if that is their preference.

Risks and Benefits

There are no known risks involved in this project; it is possible that as families reflect on past experiences, they may remember painful events related to their adopting a child internationally. However, the process of interviewing often proves more cathartic than painful. Families will be aware that their input will be used to potentially benefit other families adjusting to the international adoption process.

This project also has the potential to benefit health care providers in the fields of mental health, medicine, and psychology. By gathering a greater understanding of the specific characteristics of families who have adopted a child from either Romania or Russia, health care providers will be better equipped to provide services to this population.

Confidentiality

The principal researcher, and sole interviewer, will strive to maintain confidentiality at all times. Ways of accomplishing this goal will be: using pseudonyms during the transcription of the interviews and final write-up, tapes will be stored in my home in locked file cabinets well as all

consent forms, and I will be the only person contacting the participants to set up an interview time and place. All efforts will be made to ensure privacy and confidentiality of the participants.

Informed Consent

Please see the attached informed consent form that will be presented to each interviewee before the interviews are begun.

Biographical Sketch

Deanna Linville

Doctoral candidate in Marriage and Family Therapy

Department of Human Development

College of Human Resources and Education

I have been involved with examining the experiences of families who have internationally adopted a child for the last several years while reviewing neuropsychological evaluations of children who were referred for comprehensive cognitive and emotional evaluation for multiple reasons. Last summer, I traveled to Romania with a group of doctors and worked in several institutions/orphanages for children. This endeavor has furthered my interest in learning about how adoptive parents experience the adoption process and has led me to investigate how families' strengths and resources alter their perceptions, roles and experiences with their adopted children. The conditions I saw in the institutions in Romania were desolate and disheartening. After witnessing how deprived these children were emotionally, physically, cognitively, and socially, I am strongly compelled to conduct research in my field to help professionals understand the special needs of this population of adoptive parents and adopted children.

Appendix C

Informed Consent

Project Title: International Adoption: Family Experiences Concerning Adopting a Child from Russia or Romania

Principal Investigator: Deanna Linville, Doctoral Candidate in Marriage and Family Therapy, Human Development Department

1. I hereby agree to participate in an interview in connection with the project known as International Adoption: Family Experiences Concerning Adopting a Child from Russia or Romania. I understand that my participation is voluntary, and I will be asked about my experiences related to questions of the process of adopting a child internationally.

2. I understand that I will be asked to participate in at least 1 interview, which will take no longer than 120 minutes.

3. I understand that I can withdraw from the project and the interview at any time without penalty of any kind. In the event that I withdraw from the interview or project, any tape made of the interview will be either given to me or destroyed, and no transcript will be made of the interview.

4. I understand that I will receive no compensation for my participation in this project, though I will be given a copy of the transcript for my own records.

5. I understand that there are no known risks to participating in this project, though it may be difficult at times to discuss painful experiences I wish to share. I also understand that the benefits of this project are great, as my experiences may help inform other families considering adopting internationally as well as health care professionals provide better services.

6. I understand that the interview will be audio taped. In the interview, I will be identified by a pseudonym so that by identity remains confidential and known only to Deanna Linville, the researcher.

7. The Department of Human Development has approved this project, as required, by the Institutional Review Board for Research Involving Human Subjects at Virginia Polytechnic and State University.

8. If I feel I have not been treated according to the descriptions in this form, or that my rights as a participant in the research have been violated during the course of this project, I know I can contact Dr. David Moore, Chair, IRB, Research Division, Virginia Tech, or Deanna Linville, Principal Investigator, Human Development, Virginia Tech, at the phone number listed below.

9. I voluntarily agree to participate in this study and agree to be interviewed according to the terms outlined above. I have read and understand the Informed Consent and conditions of this project. I have had all of my questions answered. I hereby acknowledge the above and give my voluntary consent for participation in this project.

_____
Signature   Date

Should I have any questions about the research project or procedures, I may contact:

Deanna Linville   Dr. Anne Prouty   Dr. David Moore
dlinvill@vt.edu   aprouty@attbi.com   (540)231-4991

I have received a copy or duplicate original of this informed consent form.

_____
Signature   Date

Appendix D

Interview Guide

Before beginning the interview, please note the date, place, interviewer, and the pseudonym to be used for the participant(s) on the tape.

Demographic Information

Are you married?

How long have you been married?

How long has it been since you adopted your first child from Romania or Russia?

How many adopted children do you have? How many biological children do you have?

What are the ages of all your children?

How would you describe your living conditions/arrangements?

Are you employed outside of your home?

Is your partner employed outside of your home?

Do your children attend public school, private schools, or home schooling?

How many hours are you at home with your family? How many hours are you at work?

Do you have any pets?

How long have you lived at your current residence?

Does anyone else live with you besides your children and partner?

Does this child have any other caregivers who you would call "primary" other than you and your partner?

Expectations

What expectations did you have about what the international adoption process would be like?

How did you decide to adopt a child from Romania or Russia?

How did you prepare for the adoption?

How much time passed from the time you decided to adopt a child internationally until you actually adopted the child?

How have your experiences in the international adoption process been different or similar to your expectations about what it would be like?

Were there any surprises for you throughout the entire adoption process? If so, what have been the surprises?

Family Roles and Rules throughout Adoption Process

How would you describe each of your family members' roles during every day life?

How would you describe each of your family members' roles during stressful times?

How would you describe your family throughout the adoption process?

How would you describe your marital relationship throughout the adoption process?

Role of Mental and Medical Health Professionals

What were your expectations about how the mental health/medical professionals would serve you during this adoption process?

How have your experiences with health care professionals been different or the same as your expectations?

How have health care professionals been unhelpful or helpful?

What do you see as the most helpful and important roles of health care professionals throughout the adoption process?

Social Response to Adoption

How did friends and family respond to your decision to adopt from Russia or Romania?

How have friends and family been supportive or not supportive throughout the process?

What role do friends and family play in your adopted child's life?

Comparison of Domestic and International Adoption

What are the similarities and differences you see between adopting a child domestically and internationally?

Did you consider domestic adoption? How did you choose international adoption versus domestic adoption?

Advice for other Preadoptive Families

What are some strengths that your family has utilized during this process?

What resources have you utilized during the adoption process?

What has been the most helpful and most harmful to you individually, and to your family throughout the adoption process?

What advice would you give to another family or families planning to adopt from Romania or Russia?

Appendix E

International Adoption: Family Experiences of Adopting a

Child from Russia or Romania

Coding Scheme-Draft One

100 Demographic Information

      101 Characteristics of Parents

      102 Living Conditions

      103 Length of Time since Adoption

      104 Age of Children at Adoption

      105 Country Child(ren) Adopted from

      106 Reasons for IA Adoption

200 Schooling

      207 Type of Schooling

      208 Services Provided through Schools

      208 Satisfaction of School Services

      210 Difficulty/Ease of Getting Services

300 Expectations

      311 Of Adoption Process

      312 Of Parenting

      313 Of Child

      314 Of Agency

      315 Of Society

400 Experience of Adoption Process

      416 Difficulty/Ease of Adoption Process

      417 Decision of Which Child; How many children to adopt

      418 Retrieval of Child

      419 Conditions of the Institution

420 Length of Time between Decision to Adopt and Actual Adoption

421 Agency Helpful/Not Helpful

422 Preparation for Adoption

423 Different/Similar to Expectations

424 Surprises

500 Family Roles and Rules

526 Pre adoption

527 Post adoption

529 Couple/Parent Rules, Structure

529 Couple/Parent Roles

600 Family Functioning

630 Strain on Primary Relationships

631 Making Sense of Adoption Experience

632 Changes in Family Structure

633 Adaptation of Family

634 Parenting techniques

635 Sibling Relationship

636 Family Resilience

637 Family Strengths

700 Child Characteristics

738 Positive attributes

739 Negative attributes

740 Child's Personality

741 Child's Appearance

800 Special Needs of Adoptive Child(ren)

842 Physical Diagnoses

843 Mental Health Diagnoses

844 Learning Disabilities

845 Speech and Language Diagnoses

846 Emotional Concerns

847 Behavioral Concerns

848 Social Concerns

900 Services Provided for Child

949 School Services (including Special Ed)

950 Speech and Language Services

951 Mental Health Services

952 Medical Services

1000 Adequacy of Services

1053 Adequacy of Medical Services

1054 Adequacy of Mental Health Services

1055 Adequacy of School/Educational Services

1056 Adequacy of Speech and Language Services

1100 Social Response to Adoption

1157 Family Response

1158 Friend Response

1159 Society's Response in General

1160 Changes in Relationships

1200 Comparison of Domestic to International Adoption

1261 Difficulty/Ease of Process

1262 Financial Cost

1263 Contact with Bio Family

1264 Preadoptive history

1265 Reasons for Choosing IA over DA

1300 Advice to other Preadoptive Families

      1366 Methods of Preparing

      1367 What to Prepare for

      1368 Resources Utilized Pre- and Post-adoption

      1369 Thing Lost from Experience

      1370 Things Gained from Experience

      1371 Overall Perspective of Experience

Appendix F

International Adoption: Family Experiences of Adopting a

Child from Russia or Romania

Coding Scheme-Draft Eight

Overarching Theme:

Perseverance and Uniqueness Fosters Resiliency in Families with Special Needs

100 Experience of Adoption Process

    101 Comparison of Domestic to International Adoption

    102 Difficulty/Ease of Process

    103 Adoption Characteristics

        a) age of child at adoption

        b) length of time since adoption

        c) length of time between decision to adopt and actual adoption

        d) bringing child (ren) home

        e) conditions of institution

        f) child's preadoptive history

    104 Decisions around adoption (rationale, how many, which children, which country)

    105 Agency Helpful/Not Helpful

    106 Preparation for Adoption

    107 Experiences as they compare to Expectations

    108 Advice to Preadoptive Families

    109 Overall Perspective

200 Family Metamorphosis

    210 Family Roles

    211 Emotional Strain

        a) primary relationships

b) individual

212 Adaptation of Family

213 Parenting Techniques

214 Sibling Relationship

215 Family Resilience

216 Connection to Child's Country of Origin

300 Child Characteristics

317 Positive attributes

318 Negative behaviors

319 Child's Personality

320 Child's Appearance

321 Child's Diagnoses

a) medical

b) mental health

c) learning disabilities

d) speech and language diagnoses

400 Social Response to Adoption

422 Family Response

423 Friend Response

424 Society's Response in General

425 Services Provided

a) school services

b) speech and language services

c) mental health services

d) medical services

426 Adequacy of services

DEANNA LINVILLE, Ph.D.

EDUCATION

Present	**Behavioral Health Fellowship (graduation date: August, 2003)**
	University of Chicago
	Chicago Center for Family Health
	Behavioral Health Fellowship
May, 2003	**Ph.D.: Human Development**
	Virginia Polytechnic Institute and State University
	Specialization in Marriage and Family Therapy
	GPA: 3.89
May, 2000	**M.S.: Human Development and Family Studies**
	Virginia Polytechnic Institute and State University, NOVA Center
	Specialization in Marriage and Family Therapy
	GPA: 3.9
May, 1997	**B. S.: Psychology and Family & Child Development**
	Virginia Polytechnic Institute and State University
	Majors: Psychology, Family/Child Development
	Overall GPA: 3.3
	Psychology GPA: 3.4

CLINICAL EXPERIENCE

2002 – Present	**MacNeal Hospital,** Berwyn, IL
	Behavioral health fellow providing therapy for families and individuals as a part of a collaborative health team and medical residency program.
2002 – Present	**Gilda's Club,** Chicago, IL
	Behavioral health fellow working with children and families learning to live with cancer. Facilitating a group for women in their 20s and 30s living with cancer, as well as, a children's' bereavement group.
2002 – Present	**Chicago Center for Family Health,** Chicago, IL
	Therapist intern for families and individuals as part of the Chicago Center for Family health fellowship.

2001 – 2002	**Family Therapy Center,** Blacksburg, VA
	Therapist intern for families and individuals as part of Virginia Tech's Marriage and Family Therapy Doctoral Program.
2000 – 2001	**Adult Day Services,** Blacksburg, VA.
	Facilitator of a caregiver support group for those with a chronically ill family member.
1999 – 2000	**Church Street Center,** Vienna, VA
	Therapist intern for families in a private practice setting who present with a diversity of problems.
1998 – 2000	**Kaleidoscope,** Falls Church, VA
	Relief counselor in a shelter for abused and neglected children.
1998 – 2000	**Alternative House,** Vienna, VA
	Therapist intern for troubled adolescents in a residential treatment program and their families.
1998 – 2000	**Center for Family Services,** Falls Church, VA
	Therapist intern for families as a part of Virginia Tech's Marriage and Family Therapy program.
1999	**Virginia Tech,** Falls Church, VA.
	Co-facilitator of an anger management group for men court ordered to attend 12-week program for learning skills to deal with anger in a nonviolent way.

RESEARCH EXPERIENCE

2002 – Present	**MacNeal Family Practice Center,** Chicago, IL.
	Research associate to Dr. Bob Sholtes, conducting qualitative analysis of pregnant teenagers and their experience with intimate partner violence (Study funded by Irving Harris Foundation).
2002	**Virginia Tech,** Blacksburg, VA.
	Research assistant to Dr. Jay Mancini, assessed community connections and testing a community capacity model (Study funded by USDA Children, Youth, and Families At-Risk Initiative).

2000 – 2002	**Dr. Federici and Associates,** Alexandria, VA
	Research specialist for Dr. Federici, Dr. Lisa Albers, Dr. Pat Mason, and Dr. Dana Johnson, interpreted neuropsychological evaluations and analyzed the profiles, needs and struggles of international adoptees.
2001 - 2002	**Virginia Tech,** Blacksburg, VA.
	Research assistant to Dr. Fred Piercy, examined graduate students' perspectives and experiences in the Human Development department at Virginia Tech via focus groups and interviews.
2001 – 2002	**Virginia Tech,** Blacksburg, VA.
	Conducted a pilot study to understand the international adoption experiences of parents with both the health care system and the adoption process. Gained an understanding about parents' expectations of what the adoption process would be like in comparison with their actual experiences.
2000 – 2001	**Virginia Tech,** Blacksburg, VA.
	Research associate to Dr. Gloria Bird, examined couple negotiation strategies and levels of emotional distress in married partners.
1999 - 2000	**Virginia Tech,** Falls Church, VA.
	Implemented a study examining youth violence and how it related to parental monitoring and participation in extracurricular activities in a sample of 269 high school students.
1999 – 2000	**Virginia Tech,** Falls Church, VA
	Research assistant to Dr. Angela Huebner, worked on Virginia Adolescent Resilience Assessment Project.
1997 - 2000	**Virginia Tech,** Falls Church, VA.
	Research assistant to Dr. Sandra Stith, worked on a NIMH grant project testing a model of couples' therapy in domestic violence situations.

TEACHING EXPERIENCE

2003	**MacNeal Family Practice Center,** Oak Park, IL.

Responsible for the reviewing of clinical video tapes with family practice residents and teaching them about patient/doctor relationship building skills as well as communication skills.

2001 - 2002   **Virginia Tech,** Blacksburg, VA

Sole instructor for an undergraduate class of 110 students during the Fall and Spring semesters- Marriage and Family Relationships (HD 3324). Was responsible for all of the lecturing, grading, preparation, and guidance of students.

2002   **Virginia Tech,** Blacksburg, VA.

Teaching assistant for Dr. Katherine Allen, responsible for grading, exam development, and administrative work for Addictions in the family systems class. Also taught the family counseling portion of the class which included six lectures.

2000 - 2001   **Virginia Tech,** Blacksburg, VA.

Teaching assistant for Dr. Art Buikema, responsible for all of the grading and administrative work for Addictions in the family systems class.

PUBLICATION CREDITS

Johnson DE, Federici RS, Tabacaru C, Health Care Volunteers. Incidence of hepatitis B and C and HIV in older children and adolescents institutionalized since birth. Pediatr Res 51:152A, 2002. (Abstract – I am part of the Health Care Volunteers Team)

Johnson DE, Mason P, Federici RS, Tabacaru C, Health Care Volunteers. Pre- and post-pubertal growth in profoundly deprived institutionalized children. Pediatr Res 51:192A, 2002. (Abstract – I am part of the Health Care Volunteers Team)

PROFESSIONAL WRITING

Linville, D., Lambert-Shute, J., Fruhauf, C., Piercy, F. (2002). Using participatory focus groups of graduate students to improve academic departments: A case example. *Qualitative Report*. (In press)

Linville, Deanna. (2001). Orphans of Romania: Doctoral student Deanna Linville sees a painful face of childhood. *The Family Therapy Center: Help for Relationships.*

Linville, D., Hertlein, K., & Prouty, A. (2002). Medical family therapy efficacy: Reflecting on necessity of collaborative health care teams. *Feminist Family Therapy.* (Under Review)

Yorgason, J.B., Linville, D.C., & Zitzman, B. (2002). Mental Health among college students: Do those who need services know about and use them? *Journal of College Student Psychotherapy.* (Under Review)

Linville, D., Albers, L., Federici, R., & Johnson, D. (2003). Neuropsychological profiles of children adopted from Eastern European Institutions. (In preparation)

Linville, D., Huebner, A. (2003). The analysis of extracurricular activities and their relationship to youth violence. (In preparation)

PROFESSIONAL ORGANIZATION MEMBERSHIP

2002 – Present   Student Member, Collaborative Family Healthcare Association

1997 – Present   Student Member, American Association for Marriage and Family Therapy

EXPERIENCE RELATED TO FAMILIES & PROFESSIONAL PRACTICE

2002 – Present   **Oak Park YMCA,** Oak Park, IL.

Private swim lesson instructor for children and adults of all ages, gender, and ethnicity.

2001 - 2002   **Sunfish Swim Team,** Blacksburg, VA.

Assistant swim coach for beginning swimmers between the ages of 6 and 12 years old.

2001   **Adult Day Services,** Blacksburg, VA.

Entered participants' information into an access database.

2000 - 2001   **Adult Day Services,** Blacksburg, VA

Helped with the care of Alzheimer's patients at Adult Day Services. Interacted with participants by running activities including crafts, exercising, discussions, and basic daily activities.

2000 - 2001   **Virginia Tech,** Blacksburg, VA.

Graduate assistant for Dr. Janet Sawyers, director of graduate studies. Produced the monthly departmental newsletter and helped design the departmental web page.

1996 - 1999   **Shady Acres Recreation Association**, Richmond, VA

Swim team head coach for seventy children of all ages.

1997 – 1999   **Virginia Tech,** Falls Church, VA

Assisted the director of public affairs in marketing, recruitment, and human resources.

1997 - 1999   **Virginia Tech,** Falls Church, VA.

Assisted the program director of the Family and Child Development department. Coordinated and planned interview day and the alumni conference as well as worked on several clinical and research projects.

1996 - 1998   **Shady Acres Recreation Association,** Richmond, VA

Head manager of the pool during summer swim season and was responsible for supervising lifeguards, scheduling, and maintaining proper pool chemistry and cleanliness.

SERVICE WORK

2003   **AAMFT,** Washington, D.C.

Abstract reviewer for the 2003 AAMFT conference in Long Beach, California.

2001   **Care for Children International,** Alexandria, VA.

Traveled to Romania with team of doctors to assess and help institutionalized children in impoverished conditions and worked to move them to rehabilitation centers.

1997 - 1998   **George Mason High School,** Falls Church, VA

Worked on a team with other graduate students to train high school students how to mentor middle school students and handle issues that may arise.

1995 - 1997   **RAFT Crisis Hotline,** Blacksburg, VA

Counseled and provided information to callers with problems. Also, referred emergency situations to the appropriate authorities.

1996   **Y.M.C.A.,** Blacksburg, VA

Served as a mentor and tutor for students at Blacksburg High School

1996   **Y.M.C.A,** Blacksburg, VA

Volunteer for the Values Program and worked on a committee with five members to develop workshops teaching leadership skills to students at Blacksburg High School.

1995 - 1997   **Montgomery County Schools,** Blacksburg, VA

Volunteer for Big Brother/Big Sisters Program. Served as a mentor and tutor for a third and fourth grade student.

PRESENTATIONS

June, 2003   MacNeal Hospital, Chicago, IL

Presented on screening tools, treatment protocols and rates of substance abuse to residents in the MacNeal Family Practice Center.

May, 2003   MacNeal Hospital, Chicago, IL.

Presented on screening tools, treatment protocols and rates of domestic violence to residents and physicians at MacNeal Hospital.

April, 2003   Gilda's Club, Chicago, IL.

Presented to Gilda's club members and their friends and family on "cancer and the family." Discussed ways in which chronic illness can affect family functioning and relationships. Focused primarily on communication and problem solving skills.

October, 2002   MacNeal Family Practice Center, Berwyn, IL.

Presented on screening tools, treatment protocols and rates of domestic violence to residents and physicians in the family practice center.

Spring, 2002   Virginia Tech, Blacksburg, VA

Invited guest speaker to an upper-level undergraduate class on Addictions in the Family System. Presentations focused on therapeutic interventions

with families who struggle with substance abuse as well as the spiritual component to substance abuse treatment.

May, 2002	Annual Pediatrics Conference, Baltimore, MD.
	Poster presentation on profiles of international adoptees, health services most likely to be utilized by international adoptees and their families, and comparisons of preadoptive medical histories to post adoptive medical histories.
April, 2001	Annual Pediatrics Conference, Baltimore, MD.
	Presented research on international adoption data and variables/problems/risk factors of international adoptees and their families.
March, 2001	Human Resources Research Day, Blacksburg, VA.
	Presented research on couples negotiation strategies and levels of emotional distress.

AWARDS, HONORS, ACTIVITIES

2003	Recipient of the Graduate Research Development Project Award, Virginia Polytechnic Institute and State University (Award $250)
2002 - 2003	Recipient of the Faculty Campaign Graduate Student Scholarship, Virginia Polytechnic Institute and State University (Award: $500)
2001 - 2002	Recipient of the James D. Moran Memorial Thesis/Dissertation Award, Virginia Polytechnic Institute and State University (Award: $750)
1995 - 1997	Psi Chi Honor Society, National Honor Society
1994 - 1997	Dean's List
1994 - 1997	Athletic Directors' Honor Roll
1993 - 1997	Varsity Cross Country, Track, and Swim Teams